IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF WEST VIRGINIA

KARLA K. DOZIER,

Plaintiff,

v. Civil Action No. 5:08-CV-174

MICHAEL J. ASTRUE,
Commissioner of Social Security,

Defendant.

REPORT AND RECOMMENDATION
SOCIAL SECURITY

I. Introduction

A. Background

Plaintiff, Karla K. Dozier, (Claimant), filed a Complaint on November 26, 2008 seeking Judicial review pursuant to 42 U.S.C. § 405(g) of an adverse decision by Defendant, Commissioner of Social Security, (Commissioner).[1] Commissioner filed his Answer on February 3, 2009.[2] Claimant filed her Motion for Summary Judgment on March 3, 2009.[3] Commissioner filed his Motion for Summary Judgment on May 4, 2009.[4]

B. The Pleadings

1. Plaintiff's Brief in Support of Motion for Summary Judgment.

2. Defendant's Brief in Support of Motion for Summary Judgment.

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[1] Docket No. 1.

[2] Docket No. 10.

[3] Docket No. 13.

[4] Docket No. 17.

C. Recommendation

I recommend that:

1. Claimant's Motion for Summary Judgment be **DENIED AND** this action be **REMANDED** because the ALJ failed to consider and give appropriate weight to the 2002 determination of ALJ Stark finding Claimant to be disabled. On remand, the ALJ must consider the prior finding and give it appropriate weight in light of all relevant evidence. Additionally, the ALJ must explicitly indicate the weight given to all relevant evidence in reaching his determination.

2. Commissioner's Motion for Summary Judgment be **DENIED** for the same reasons set forth above.

II. Facts

A. Procedural History

On January 3, 2006, Claimant filed an application for Supplemental Security Income ("SSI") alleging the onset date of disability to be January 17, 2008 due to back pain and depression. (Tr. 126). This application was denied initially (Tr. 97), and upon reconsideration on October 11, 2006. (Tr. 103). On December 12, 2006, Claimant submitted a request for a hearing before an ALJ. (Tr. 107). A hearing was held on July 15, 2008 at which Claimant and a vocational expert testified. (Tr. 42-76). The ALJ denied the claim by written decision on September 12, 2008 finding that Claimant was not disabled because, although she could no longer perform her past relevant work, she could perform other specific unskilled sedentary work that existed in significant numbers in the national economy. (Tr. 32-41). Claimant's Request for Review was timely filed on October 16, 2008. (Tr. 8). On October 23, 2008, the Appeals

Council denied the request. (Tr. 1-3). Therefore, on October 23, 2008, the ALJ's decision became the final decision of the Commissioner. Having exhausted her administrative remedies, Claimant filed this action, which proceeded as set forth above.

B. Personal History

Claimant was forty-six years old on the alleged onset date of January 17, 2006. Claimant's date of birth is April 26, 1959 (Tr. 138). Claimant was therefore considered a "younger person," under age 50, under the Commissioner's regulations on both the onset date and date of the ALJ's decision. 20 C.F.R. §§ 404.156(c), 416.963(c) (2008). From the date of the ALJ's decision, Claimant has been a "person closely approaching advanced age" within the meaning of the regulations. 20 C.F.R. § 404.1563(d), 416.963(d) (2009). Claimant graduated from high school. (Tr. 148). Claimant has prior work experience as a data entry clerk in the mortgage industry. (Tr. 144).

C. Medical History

The following medical history is relevant to the issues of whether the ALJ erred in failing to give appropriate weight to the treating physicians' opinions which led to an initial disability finding and whether he erred in determining Claimant's RFC:

Psychosocial Assessment, Jessie L. Rayl, M.A., LPC, Eastridge Health Systems, Berkeley County Office, 4/14/99 (Tr. 198-200)

Psychiatric History: In and out of various drug and alcohol treatment centers; never stayed with any program. No previous history of mental illness. No family history of mental illness or substance abuse.

Substance Abuse History: History of crack cocaine addiction. Began smoking "reefer" as a teenager; began smoking crack when she was 27. Stopped using all drugs in 1996. Drinks alcohol occasionally.

Family and Childhood History: Was raised by her grandparents; saw her mother on the weekends. Did not have a good relationship with her father as a child but is on a friendly basis

now. Denied ever being sexually or physically abused. Had friends in school; did well academically. Graduated from high school.

Adult History: Worked in fashion stores and accounting. Never been able to keep jobs long because of her drug use or because of personality conflicts with coworkers. Never married. Had an abortion and had PTSD symptoms for years.

Social Assessment: Very little socialization since giving up drugs.

Mental Status Evaluation: Reportedly feels hyperactive, worked up, tense, and anxious most of the time. Has days where depressed, despondent, and isolative. Decreased appetite recently. Sleeps four to five hours each night. Denied any suicidal ideation, previous attempts, homicidal ideation or attempts, violence to self or others, hallucinations or delusions. Obsessed with legal issues and treatment of her mother. No hygiene difficulties. Abrupt but friendly manner; affect mixed with depression and euphoria. Some flight of ideas; able to be redirected but with difficulty. No psychosis present. Average to above-average intellect. Fair insight.

Recommendations: individual psychotherapy; psychiatric evaluation.

S.O.A.P. Notes, Kerry V. Bertschinger, D.C., 1/3/01 - 6/21/02 (Tr. 201-230)

1/3/01

Subjective: pain in lower back and hip is worse; popping/cracking sensation in left and right groin area, pain across tops of left and right shoulders, left and right shoulder pain, pain and numbness in left and right arm, popping and cracking in joints, and pain in middle back is improved.
Objective: muscle tightness in cervical spine, decreased range of motion in cervical spine, muscle tightness in upper thoracic spine, decreased range of motion in upper thoracic spine, muscle tightness in thoraco-lumbar spine, and decreased range of motion in thoraco-lumbar spine have improved; muscle tightness in lumbo-sacral spine, decreased range of motion in lumbo-sacral spine is worse.
Assessment: patient continues to slowly improve.
Plan: return in two weeks
Treatment: specific posterior adjustive procedures administered. Specific side posture adjustive procedures were administered to the sacram. Affected extremities were adjusted.

1/18/01

Subjective: pain in lower back bilaterally, pain in hip bilaterally, popping and cracking in left and right groin area, popping and cracking in joints, pain in middle back, and pain and numbness in left and right arm have slightly improved; pain across tops of left and right shoulders, left and right shoulder pain is slightly worse.
Objective: muscle tightness in cervical spin, muscle tightness in lumbo-sacral spine, decreased range of motion in thoraco-lumbar spine, muscle tightness in thoraco-lumbar spine, and decreased range of motion in thoraco-lumbar spine have improved; decreased range of motion in cervical spine, muscle tightness in upper thoracic spine, and decreased range of motion in upper

thoracic spine have slightly improved.
Assessment: overall condition is worse
Plan: return in two weeks
Treatment: Specific posterior adjustive procedures were administered. Affected extremities were adjusted.

2/1/01
Subjective: pain in lower back bilaterally; pin in hip bilaterally; popping/cracking in left and right groin area; pain across tops of left and right shoulders; left and right shoulder pain; pain and numbness in left and right arm; popping and cracking in joints; middle back pain; pain in back of upper arm and arm pit bilaterally; pain in lower and middle back. Stated fell on ice and aggravated back.
Objective: muscle tightness in cervical spine; decreased range of motion in cervical spine; muscle tightness in upper thoracic spine; decreased range of motion in upper thoracic spine; muscle tightness in lumbo-sacral spine; decreased range of motion in lumbo-sacral spine; muscle tightness in thoraco-lumbar spine; decreased range of motion in thoraco-lumbar spine; muscle spasms in thoraco-lumbar spine and lumbo-sacral spine; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine.
Assessments: Flare-ups in patient's condition
Plan: return in one day
Treatment: Specific posterior adjustive procedures were administered. Affected extremities were adjusted. Cranial manipulation performed. Lumbar stretch.
Diagnosis: lumbar sprain; lumbago

2/2/01
Subjective: pain in back of upper arm and arm pit bilaterally is slightly improved; pain in lower and middle back is slightly improved. Stated fell on ice and aggravated back.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are improved; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is improved.
Assessment: patient continues to slowly improve.
Plan: return next week
Treatment: Specific posterior adjustive procedures were administered. Affected extremities were adjusted. Cranial manipulation performed. Neck stretch; lumbar stretch.

2/7/01
Subjective: pain in back of upper arm and arm pit bilaterally is slightly worse; pain in lower and middle back is slightly worse; tightness in neck. Stated lifting mother aggravates neck and shoulders.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are improved; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is improved; muscle tightness in cervical spine.
Plan: return next week
Treatment: Specific posterior adjustive procedures were administered. Affected extremities were adjusted. Cranial manipulation. Neck stretch; lumbar stretch.

2/15/01
Subjective: pain in back of upper arm and arm pit bilaterally is slightly worse; pain in lower and middle back is slightly worse; tightness in neck is slightly worse. Stated lifting mother aggravates neck and shoulders.
Objective: Muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are slightly worse; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is slightly worse; muscle tightness in cervical spine is slightly improved.
Plan: return next week
Treatment: Specific posterior adjustive procedures were administered. Affected extremities were adjusted; cranial manipulation.

3/12/01
Subjective: no change in pain in back of upper arm and arm pit bilaterally; no change in pain in lower and middle back; no change in tightness of neck.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are slightly improved; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is slightly improved; muscle tightness in cervical spine is slightly improved.
Plan: return next week
Treatment: Specific posterior adjustive procedures were administered. Affected extremities were adjusted; cranial manipulations performed.

5/23/01
Subjective: pain in back of upper arm and arm pit bilaterally is worse; pain in lower and middle back is worse; tightness in neck is worse; cracking of joints. Stated neglected own health while caring for mother.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are worse; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is worse; muscle tightness in cervical spine is worse.
Assessment: Flare-ups in condition.
Plan: return next week
Treatment: Specific anterior and posterior adjustive procedures were administered. Affected extremities were adjusted; neck stretch; lumbar stretch. Infrared treatment; therapy performed.

5/30/01
Subjective: no change in pain in back of upper arm and arm pit bilaterally; pain in lower and middle back is slightly improved; no change in tightness in neck; cracking in joints.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are slightly improved; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is slightly improved; muscle tightness in cervical spine is slightly improved.
Assessment: overall assessment is slightly improved
Treatment: Anterior adjustive procedures administered; specific posterior adjustive procedures administered. Cranial manipulation. Neck stretch. Infrared treatment; therapy performed.

8/8/01

Subjective: pain in back of upper arm and arm pit bilaterally is slightly worse; pain in lower and middle back is slightly worse; tightness in neck is slightly worse; cracking in joints is slightly worse.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are slightly worse; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is slightly worse; muscle tightness in cervical spine is very slightly worse.
Treatment: anterior adjustive procedures administered; specific posterior adjustive procedures administered. Cranial manipulation performed.

8/15/01
Subjective: pain in back of upper arm and arm pit bilaterally is worse; pain in lower and middle back is worse; no change in tightness in neck; no change in cracking in joints.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are slightly improved; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is slightly improved; no change in muscle tightness in cervical spine.
Assessment: overall condition is slightly worse
Plan: return in two weeks
Treatment: anterior adjustive procedures; specific posterior adjustive procedures. Cranial manipulation performed.

9/5/01
Subjective: pain in back of upper arm and arm pit bilaterally is very slightly improved; pain in lower and middle back is very slightly improved; tightness in neck is slightly improved; cracking in joints is slightly improved.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are slightly improved; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is slightly improved; muscle tightness in cervical spine is slightly improved.
Assessment: overall assessment is slightly improved
Treatment: Anterior adjustive procedures administered; specific posterior adjustive procedures administered. Lumbar stretch. Cranial manipulation performed.

9/19/01
Subjective: no change in pain in back of upper arm and arm pit bilaterally; no change in pain in lower and middle back; no change in tightness in neck; no change in cracking of joints.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are slightly improved; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is slightly improved; muscle tightness in cervical spine is slightly improved.
Assessment: overall assessment is slightly improved
Plan: return in three weeks
Treatment: anterior adjustive procedures administered; specific posterior adjustive procedures administered. Cranial manipulation performed.

10/10/01
Subjective: no change in pain in back of upper arm and arm pit bilaterally; no change in pain in

lower and middle back; no change in tightness in neck; no change in cracking of joints.
Objective: no change in muscle spasms in thoraco-lumbar spine and lumbo-sacral spine; no change in decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine; muscle tightness in cervical spine is very slightly improved.
Assessment: overall assessment is slightly improved
Plan: return in four weeks
Treatment: anterior adjustive procedures administered; specific posterior adjustive procedures administered. Cranial manipulation performed.

11/7/01
Subjective: pain in back of upper arm and arm pit bilaterally is worse; pain in lower and middle back is worse; tightness in neck is worse; cracking of joints is worse.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are slightly worse; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is slightly worse; muscle tightness in cervical spine is slightly worse.
Assessment: overall condition is slightly worse
Plan: return in four weeks
Treatment: specific posterior adjustive procedures administered; specific side posture and adjustive procedures administered. Cranial manipulation performed. Neck distraction.

12/5/01
Subjective: pain in back of upper arm and arm pit bilaterally is very slightly improved; pain in lower and middle back is very slightly improved; tightness in neck is very slightly improved; no change in cracking of joints.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are slightly improved; decreased range of motion in thoraco-lumbar spine and lumbo-sacral spine is slightly improved; muscle tightness in cervical spine is slightly improved.
Assessment: patient continues to slowly improve.
Plan: return on as needed basis
Treatment: specific posterior adjustive procedures administered.

12/17/01
Subjective: no change in pain in back of upper arm and arm pit bilaterally; pain in lower and middle back is slightly worse; tightness in neck is slightly improved; no change in cracking of joints.
Objective: muscle spasms in thoraco-lumbar spine and lumbo-sacral spine are slightly worse; decreased range of motion in the thoraco-lumbar spine and lumbo-sacral spine is slightly worse; no change in muscle tightness in cervical spine.
Assessment: overall condition is slightly worse
Plan: return in one day
Treatment: specific posterior adjustive procedures were administered. Cranial manipulation.

4/11/02
Subjective: Stated condition is chronic and continually worsening. Pain in arms bilaterally;

joints crack; pain and stiffness in neck bilaterally; light-headed; pain and stiffness in upper back bilaterally, ribcage pain/pulling sensation; pain in lower back bilaterally.
Objective: Shoulder Depressor test of the cervical spine was positive on the left; Foramina Compression test of the cervical spine was negative; Lasegue's test of the hip was negative bilaterally; Patrick Fabere's test of the hip was negative bilaterally. Muscle tightness in cervical spine on right; decreased range of motion in cervical spine on right; muscle tightness in upper thoracic spine bilaterally; decreased range of motion in the upper thoracic spine bilaterally; muscle tightness in the mid-thoracic spine bilaterally; decreased range of motion in the mid-thoracic spine; muscle tightness in the lumbo-sacral spine bilaterally; decreased range of motion in the lumbo-sacral spine bilaterally.
Assessment: flare-ups in condition
Plan: return next week
Treatment: specific posterior adjustive procedures administered. Cranial manipulation; neck distraction.
Diagnosis: degeneration of cervical intervertebral disc; myalgia and myositis, unspecified.

4/29/02
Subjective: Stated condition is chronic and continually worsening. Pain in arms bilaterally is very slightly improved; no change in cracking of joints; pain in neck bilaterally is very slightly improved; stiffness in neck bilaterally is very slightly improved; light-headed; no change in pain in upper-back bilaterally; no change in stiffness in upper back bilaterally; ribcage pain/pulling sensation is slightly improved; no change in pain in lower back bilaterally.
Objective: muscle tightness in cervical spine on right is slightly improved; decreased range of motion in cervical spine on right is slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in mid-thoracic spine bilaterally is very slightly improved; decreased range of motion in mid-thoracic spine is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is slightly improved.
Assessment: continues to slowly improve
Plan: return in two weeks
Treatment: specific posterior adjustive procedures administered. Cranial manipulation; neck distraction.

5/31/02
Subjective: Stated condition is chronic and continually worsening. No change in pain in arms bilaterally; no change in cracking of joints; no change in pain in neck bilaterally; no change in stiffness in neck bilaterally; light-headed; pain in upper back bilaterally is very slightly worse; stiffness in upper back bilaterally is very slightly worse; ribcage pain/pulling sensation is slightly worse; pain in lower back bilaterally is very slightly worse.
Objective: muscle tightness in cervical spine on right is slightly worse; decreased range of motion in cervical spine on right is slightly worse; muscle tightness in upper thoracic spine bilaterally is worse; decreased range of motion in upper thoracic spine bilaterally is worse; muscle tightness in mid-thoracic spine bilaterally is worse; decreased range of motion in mid-

thoracic spine is worse; muscle tightness in lumbo-sacral spine bilaterally is very slightly worse; decreased range of motion in lumbo-sacral spine bilaterally is very slightly worse.
Assessment: overall condition is slightly worse
Treatment: specific posterior adjustive procedures were administered. Cranial manipulation.

6/7/02
Subjective: Stated condition is chronic and continually worsening. Pain in arms bilaterally is very slightly worse; cracking of joints is very slightly worse; pain in neck bilaterally is slightly worse; stiffness in neck bilaterally is slightly worse; light-headed; pain in upper back bilaterally is slightly worse; stiffness in upper back bilaterally is slightly worse; ribcage pain/pulling sensation is slightly worse; pain in lower back bilaterally is very slightly worse.
Objective: muscle tightness in cervical spine on right is very slightly worse; decreased range of motion in cervical spine on right is very slightly worse; muscle tightness in upper thoracic spine bilaterally is slightly worse; decreased range of motion in upper thoracic spine bilaterally is slightly worse; muscle tightness in mid-thoracic spine bilaterally is very slightly worse; decreased range of motion in mid-thoracic spine is very slightly worse; muscle tightness in lumbo-sacral spine bilaterally is very slightly worse; decreased range of motion in lumbo-sacral spine bilaterally is very slightly worse.
Plan: return in two weeks
Treatment: Specific posterior adjustive procedures were administered. Cranial manipulation.

6/21/02
Subjective: no change in pain in arms bilaterally; no change in cracking of joints; no change in pain in neck bilaterally; no change in stiffness in neck bilaterally; light-headed condition is slightly improved; no change in pain in upper back bilaterally; no change in stiffness in upper back bilaterally; ribcage pain/pulling sensation is improved; no change in pain in lower back bilaterally.
Objective: muscle tightness in cervical spine on the right is improved; decreased range of motion in cervical spine on right is improved; muscle tightness in upper thoracic spine bilaterally is improved; decreased range of motion in upper thoracic spine bilaterally is improved; muscle tightness in mid-thoracic spine bilaterally is improved; decreased range of motion in mid-thoracic spine is improved; muscle tightness in lumbo-sacral spine bilaterally is improved; decreased range of motion in lumbo-sacral spine bilaterally is improved.
Assessment: continues to slowly improve
Plan: return in two weeks
Treatment: Specific posterior adjustive procedures were administered. Cranial manipulation.

4/22/02
Complaints: chronic pain in and under arms; joints cracking; shoulder stiffness; back pain
Objective: left and right arm pain; joints cracking; neck pain and stiffness; light-headed; upper back pain and stiffness; pain/pulling sensation in ribcage; low back pain
Treatment: spinal adjustments

2/1/01

Treatment: spinal adjustments

Radiology Report, John Blanco, MD, City Hospital, Inc., 6/14/2001 (Tr. 231)
Clinical Indication: disability determination
PA and Lateral Chest: Cardiovascular silhouette is normal in size and configuration; lungs appear clear. No pleural fluid noted. No bony abnormality seen.
Impression: normal chest

Magnetic Resonance Imaging Report, Hojoon Jung, MD, City Hospital, 10/5/04 (Tr. 232)
MRI of Left Knee Without Contrast
Findings: anterior and posterior ligaments are intact. Collateral ligaments are intact. No evidence of meniscal tear in medial meniscus. Evaluation of lateral meniscus demonstrates discoid configuration of the lateral meniscus without a definite tear. Seven mm osteochondral lesion involving the medial femoral condyle trochlear groove with mild subchondral edema. Moderate joint effusion.
Impression: Seven mm osteochondral lesion in medial femoral condyle trochlear groove; moderate joint effusion; discoid lateral meniscus.

Medical Records, John A. Draper, MD, FACS, 2/28/01 - 12/21/04 (Tr. 233-246)
12/21/04
Complaints: seeing a massage therapist; left knee feels better but still cracks**;** cracking in right leg but does not hurt.
Physical Exam: walking better; no effusion in either knee. Full extension of both knees and able to flex both to 130 degrees.
Medical Decision: contusion on left shoulder and left knee
Plan: treated with Bextra and encouraged to stay active. Arthroscopy not necessary

11/17/04
Complaints: left shoulder, injected during last visit, is better. Chronically tired; left knee feels better when walking. Still taking Bextra, Flexeril, and Darvocet. Overall, feeling better.
Physical Exam: able to abduct and forward flex to 120 degrees; internal and external rotation is better. Still has some crepitus in left knee; no instability. No effusion.
Medical Decision: contusion left shoulder and left knee
Plan: sounds like same body parts were injured in both accidents. Return in one month. May need arthroscopy of left knee.

11/2/04
Complaints: second automobile accident on October 28. Increased stiffness in neck and increased pain in left shoulder and left knee.
Physical Exam: Tender to palpation over the anterior aspect of the left shoulder. Can abduct and forward flex to 90 degrees. Diffusely tender over neck and lumbosacral spine. No effusion in right knee; 1-2+ effusion in left knee. Able to fully extend left knee but only flex it to 90 degrees. No instability to anterior, posterior, or varus/valgus stress.
Medical Decision: aggravation of pre-existing problems with left shoulder and left knee.

Plan: Accident should be only a temporary setback. Continue taking Darvocet and Bextra. Left shoulder injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine. Encouraged to stay as active as possible and return in two weeks.

10/14/04
Complaints: MRI of knee showed a discoid meniscus and an osteochondral lesion in trochlear groove portion of the medial femoral condyle.
Physical Exam: left knee is puffy; lateral joint line and medial joint line tenderness. No instability to anterior, posterior, or varus/valgus stress.
Radiographs: no defects shown in single tunnel view of knee
Medical Decision: contusion left knee, which may have aggravated pre-existing discoid meniscus or caused an osteochondral fracture.
Plan: Patient refused arthroscopy. Return in two months.

9/29/04
Complaints: left knee still hurting; infrequent twinges of pain in right ankle.
Physical Exam: Swelling in right ankle is down. Left knee still puffy. Pain with flexion and extension, but no instability.
Medical Decision: contusion left knee
Plan: schedule MRI of knee and return after MRI taken.

9/2/04
Complaints: Knee is better. Still seeing Dr. Bertschinger for neck and shoulders. Some pain over the lateral aspect of the ankle. Still taking Bextra and Flexeril with Darvocet for pain.
Physical Exam: Tender over medial collateral ligament. No effusion; no instability to anterior, posterior, or varus/valgus stress. Tender over knee but moving it much better. Still tender over lateral aspect of right ankle but drawer test is negative. Good inversion and eversion against resistance.
Medical Decision: contusion left knee/ lateral sprain right ankle
Plan: Continue same medicines; return in three to four weeks.

8/19/04
Complaints: Automobile accident. Pain in neck, both arms, both shoulders, left knee, and right ankle.
Physical Exam: Able to get the right shoulder through a full ROM but can only forward flex the left shoulder to 90 degrees. Pain radiating down to both elbows and oddly the right side bothers her more than the left. Tender over both medial and lateral collateral ligaments. No instability to anterior, posterior, or varus/valgus stress. Some swelling over the lateral aspect of the right ankle; drawer test is negative. No deltoid tenderness; good inversion and eversion against resistance.
Radiographs: views of left knee appear normal; three views of right ankle show some spurring.
Medical Decision: traumatic cervical strain with aggravation of bilateral shoulder problems; contusion left knee; lateral sprain right ankle.
Plan: Given Bextra, Darvocet, and Flexeril. Return in two weeks.

7/14/04
Complaints: Bextra and Skelaxin are helping. Has not done anything about her thyroid.
Plan: Recommended she visit Shenandoah Community Health out of concern for thyroid and pursue medical card. Return in two weeks.

6/9/04
Complaints: Still taking Bextra. Pain in both shoulders but not ready for another injection. Able to abduct or forward flex to about 90 degrees. Both elbows are cracking but able to fully extend both elbows; appears to have normal flexion. No effusion. Ganglion cyst on dorsum of right wrist. Cold even in hot weather.
Medical Decision: possible thyroid dysfunction
Plan: return in two months; have thyroid checked

4/7/04
Complaints: left shoulder feeling better; right shoulder hurting. Using Bextra and Skelaxin as needed.
Physical Exam: tender to palpation over tip of right acromion and has some subacromial crepitus
Medical Decision: impingement right shoulder. Shoulder infiltrated with 1% Lidocaine and injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine.
Plan: return in a few months.

2/5/04
Complaints: pain in left shoulder worse than that in right. Unable to secure a medical card.
Physical Exam: tender over tip of acromion on both shoulders. Pain with abduction and forward flexion above 70 degrees.
Medical Decision: bilateral shoulder impingement syndrome.
Shoulder infiltrated with 1% Lidocaine and injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine.
Plan: return in a few months.

11/23/03
Complaints: pain under right arm into rib area and posteriorly in periscapular area. Limited abduction and forward flexion of both shoulders. Moves right shoulder through a more normal ROM than the left. Appears to be gaining weight.
Medical Decision: bilateral impingement syndrome
Plan: Take Bextra and Skelaxin. Return in one month.

9/10/03
Complaints: pain in both shoulders; wants injection in right shoulder. Able to force right shoulder through a full ROM but has pain with abduction and forward flexion above 70 degrees. Motion limited on left.
Medical Decision: impingement both shoulders. Right shoulder infiltrated with 1% Lidocaine and injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine.
Plan: given more Bextra.

6/3/03
Complaints: pain in both shoulders; Bextra giving some relief. Limited motion of left shoulder.
Plan: left shoulder infiltrated with 1% Lidocaine and injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine.
Plan: return in a few months.

3/6/03
Complaints: fell on ice and landed on left shoulder. Pain with abduction and forward flexion; no crepitus to suggest anything broken.
Medical Decision: post-traumatic impingement right shoulder. Right shoulder infiltrated with 1% Lidocaine and injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine.
Plan: given samples of Bextra; return if condition worsens.

11/15/02
Complaints: Patient asking for another corticosteroid injection. Pain in left shoulder with abduction and forward flexion above 70 degrees.
Medical Decision: Impingement left shoulder. Left shoulder infiltrated with 1% Lidocaine and injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine.
Plan: given more samples of Bextra; return in a few months.

10/10/02
Complaints: impingement of both shoulders; feels like Bextra is helping.
Plan: continue Bextra; return in one month

9/26/02
Complaints: discomfort; unable to exercise. Dark stools; stopped Vioxx, but became more symptomatic. Signs of impingement in both shoulders.
Plan: return in two weeks

8/8/02
Complaints: pain in right shoulder similar to pain in left shoulder. Pain with abduction and forward flexion above 70 degrees. Bextra not helping as much as Vioxx.
Medical Decision: impingement right shoulder. Right shoulder infiltrated with 1% Lidocaine and injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine.
Plan: given samples of Vioxx; return in six weeks.

7/9/02
Complaints: pain in both shoulders. Asked for right shoulder injection. Vioxx isn't helping her.
Plan: given Bextra.

5/29/02
Complaints: can only abduct and forward flex to 90 degrees; very sensitive over the tip of the acromion. Left shoulder infiltrated with 1% Lidocaine and injected with 40 mg DepoMedrol and

1 cc of 1% Lidocaine.
Plan: return in one month.

1/8/02
Complaints: Only able to abduct and forward flex to 90 degrees; tender over tip of the acromion.
Medical Decision: chronic impingement left shoulder. Left shoulder infiltrated with 1% Lidocaine and injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine.
Plan: return in a few months.

9/11/01
Complaints: under stress. Subscribed medication from Dr. Rezaian.
Medical Decision: left shoulder infiltrated with 1% Lidocaine and injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine.
Plan: return in a few months.

7/31/01
Complaints: Pain in shoulders, particularly left. Can only abduct or forward flex to 90 degrees. Subacromial crepitus.
Plan: return in one month for injection in left shoulder.

6/10/01
called patient - MRI showed no definite rotator cuff tear.
Plan: return in a few months if still in pain.

5/9/01
Complaints: shoulder pain
Medical Decision: chronic impingement. Order MRI. Left shoulder infiltrated with 1% Lidocaine and injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine.
Plan: given samples of Vioxx. Will call when have results.

2/28/01
Complaints: only able to abduct or forward flex left shoulder to 90 degrees. Slipped twice on ice in January; aggravated shoulder.
Plan: given samples of Vioxx; return in one month.

Medical Records and S.O.A.P Notes, Kerry V. Bertschinger, DC 8/17/04 - 1/10/05 (Tr. 247-320)

8/17/04
Subjective: Pain worsening after automobile accident on 8/14/04. Pain in neck bilaterally; pain across tops of shoulders bilaterally; pain in arms bilaterally; tingling in upper arms bilaterally; light-headed; pain in ribcage bilaterally; pain in lower back bilaterally; aching in ankle on right; pain in shoulder bilaterally.
Objective: muscle tightness in cervical spine bilaterally; decreased range of motion in cervical spine bilaterally; muscle tightness in upper thoracic spine bilaterally; decreased range of motion

in upper thoracic spine bilaterally; muscle tightness in thoraco-lumbar spine bilaterally; decreased range of motion in thoraco-lumbar spine bilaterally; muscle tightness in lumbo-sacral spine bilaterally; decreased range of motion in lumbo-sacral spine bilaterally; muscle tightness in hip joint bilaterally.
Assessments: flare-ups in conditions
Plan: return in two days
Treatment: anterior adjustive procedures; specific posterior adjustive procedures administered. Cranial manipulation. Neck stretch.
Diagnosis: neck sprain; brachial neuritis or radiculitis nos; lumbar sprain

8/19/04
Subjective: No change in pain in neck bilaterally; no change in pain across shoulders bilaterally; no change in pain and tingling in arms bilaterally; light-headedness has improved; no change in pain in ribcage bilaterally; no change in aching in ankle on right; no change in pain in shoulder bilaterally.
Objective: muscle tightness in cervical spine bilaterally; decreased range of motion in cervical spine bilaterally; muscle tightness in upper thoracic spine bilaterally; decreased range of motion in upper thoracic spine bilaterally; muscle tightness in thoraco-lumbar spine bilaterally; decreased range of motion in thoraco-lumbar spine bilaterally; muscle tightness in lumbo-sacral spine bilaterally; decreased range of motion in lumbo-sacral spine bilaterally; muscle tightness in hip joint bilaterally.
Assessment: continues to slowly improve
Plan: return next week
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

8/23/04
Subjective: Pain in neck bilaterally is slightly improved; pain across shoulders bilaterally is very slightly improved; pain and tingling in arms bilaterally is very slightly improved; light-headedness is very slightly improved; pain in ribcage bilaterally is very slightly improved; no change in pain in lower back bilaterally; no change in aching in ankle on right; pain in shoulder bilaterally is very slightly improved; pain in left knee.
Objective: muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; no change in muscle tightness in thoraco-lumbar spine bilaterally; no change in decreased range of motion in thoraco-lumbar spine bilaterally; no change in muscle tightness in lumbo-sacral spine bilaterally; no change in decreased range of motion in lumbo-sacral spine bilaterally; no change in muscle tightness in hip joint bilaterally.
Assessment: overall condition is slightly improved
Plan: return in two days
Treatment: specific posterior adjustive procedures

8/25/04

Subjective: Pain in neck bilaterally is very slightly improved; pain across shoulders bilaterally is very slightly improved; no change in pain and tingling in arms bilaterally; light-headedness is very slightly improved; pain in ribcage bilaterally is very slightly improved; no change in pain in lower back bilaterally; aching in right ankle is very slightly improved; pain in shoulder bilaterally is very slightly improved; pain in left knee is very slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved.
Assessment: continues to slowly improve
Plan: return in two days
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed.

8/26/04
Subjective: Pain in neck bilaterally is very slightly improved; pain across shoulders bilaterally is very slightly improved; pain and tingling in arms bilaterally are very slightly improved; no change in light-headedness; pain in ribcage bilaterally is very slightly improved; no change in pain in lower back bilaterally; aching in right ankle is very slightly improved; pain in shoulder bilaterally is very slightly improved; no change in pain in left knee.
Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved.
Assessment: continues to slowly improve
Plan: return next week
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

8/30/04

Subjective: Pain in neck bilaterally is slightly improved; no change in pain across shoulders bilaterally; no change in pain and tingling in arms bilaterally; light-headedness is very slightly improved; pain in ribcage bilaterally is very slightly improved; pain in lower back bilaterally is very slightly improved; no change in aching in right ankle; no change in pain in shoulder bilaterally; no change in pain in left knee.

Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved.
Assessment: continues to slowly improve
Plan: return in two days
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

9/1/04
Subjective: Pain in neck bilaterally is slightly improved; pain across shoulders bilaterally is slightly improved; pain and tingling in arms bilaterally are slightly improved; light-headedness is slightly improved; pain in ribcage bilaterally is slightly improved; pain in lower back bilaterally is slightly improved; aching in right ankle is very slightly improved; pain in shoulder bilaterally is slightly improved; pain in left knee is slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved.
Assessment: continues to slowly improve
Plan: return in one day
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

9/2/04
Subjective: Pain in neck bilaterally is very slightly improved; pain across shoulders bilaterally is very slightly improved; pain and tingling in arms bilaterally are very slightly improved; light-headedness is slightly improved; pain in ribcage bilaterally is slightly improved; pain in lower back bilaterally is slightly improved; aching in right ankle is very slightly improved; pain in shoulder bilaterally is slightly improved; pain in left knee is very slightly improved.

Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very

slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved.
Assessment: continues to slowly improve
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

9/7/04
Subjective: Pain in neck bilaterally is very slightly improved; pain across shoulders bilaterally is very slightly improved; pain and tingling in arms bilaterally are very slightly improved; light-headedness is very slightly improved; pain in ribcage bilaterally is very slightly improved; pain in lower back bilaterally is slightly improved; aching in right ankle is slightly improved; pain in shoulder bilaterally is slightly improved; pain in left knee is slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is slightly improved; muscle tightness in lumbo-sacral spine bilaterally is slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is slightly improved; muscle tightness in hip joint bilaterally is slightly improved.
Assessment: continues to slowly improve
Plan: return in two days
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

9/10/04
Subjective: Pain in neck bilaterally is very slightly worse; pain across shoulders bilaterally is very slightly worse; pain and tingling in arms bilaterally are very slightly worse; no change in light-headedness; pain in ribcage bilaterally is very slightly worse; pain in lower back bilaterally is very slightly worse; aching in right ankle is very slightly worse; pain in shoulder bilaterally is very slightly worse; pain in left knee is very slightly worse.
Objective: Muscle tightness in cervical spine bilaterally is very slightly worse; no change in decreased range of motion in cervical spine bilaterally; muscle tightness in upper thoracic spine bilaterally is very slightly worse; decreased range of motion in upper thoracic spine bilaterally is very slightly worse; no change in muscle tightness in thoraco-lumbar spine bilaterally; no change in decreased range of motion in thoraco-lumbar spine; no change in muscle tightness in lumbo-sacral spine bilaterally; no change in decreased range of motion in lumbo-sacral spine bilaterally; muscle tightness in hip joint bilaterally is very slightly worse.
Assessment: overall condition is very slightly worse
Plan: return in three days
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

9/13/04
Subjective: Pain in neck bilaterally is slightly improved; pain across shoulders bilaterally is slightly improved; pain and tingling in arms bilaterally are slightly improved; light-headedness is improved; pain in ribcage bilaterally is slightly improved; pain in lower back bilaterally is slightly improved; aching in right ankle is very slightly improved; pain in shoulder bilaterally is very slightly improved; pain in left knee is very slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is slightly improved; muscle tightness in lumbo-sacral spine bilaterally is slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is slightly improved; muscle tightness in hip joint bilaterally is slightly improved.
Assessment: overall condition is slightly improved
Plan: return in two days
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

9/15/04
Subjective: Pain in neck bilaterally is very slightly improved; pain across shoulders bilaterally is very slightly improved; pain and tingling in arms bilaterally are very slightly improved; light-headedness is very slightly improved; pain in ribcage bilaterally is very slightly improved; no change in pain in lower back bilaterally; no change in aching in right ankle; no change in pain in shoulder bilaterally; no change in pain in left knee.
Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; no change in muscle tightness in thoraco-lumbar spine bilaterally; no change in decreased range of motion in thoraco-lumbar spine bilaterally; no change in muscle tightness in lumbo-sacral spine bilaterally; no change in decreased range of motion in lumbo-sacral spine bilaterally; no change in muscle tightness in hip joint bilaterally.
Assessment: continues to slowly improve
Plan: return in two days
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

9/17/04
Subjective: Pain in neck bilaterally is slightly improved; pain across shoulders bilaterally is slightly improved; pain and tingling in arms bilaterally are slightly improved; light-headedness is slightly improved; pain in ribcage bilaterally is slightly improved; pain in lower back bilaterally is very slightly improved; no change in aching in right ankle; pain in shoulder bilaterally is very slightly improved; no change in pain in left knee.

Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; no change in muscle tightness in lumbo-sacral spine bilaterally; no change in decreased range of motion in lumbo-sacral spine bilaterally; no change in muscle tightness in hip joint bilaterally.
Assessment: continues to slowly improve
Plan: return next week
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

9/21/04
Subjective: No change in pain in neck bilaterally; no change in pain across shoulders bilaterally; no change in pain and tingling in arms bilaterally; no change in light-headedness; no change in pain in ribcage bilaterally; no change in pain in lower back bilaterally; no change in aching in right ankle; no change in pain in shoulder bilaterally; no change in pain in left knee.

Objective: No change in muscle tightness in cervical spine bilaterally; no change in decreased range of motion in cervical spine bilaterally; muscle tightness in upper thoracic spine bilaterally is very slightly worse; decreased range of motion in upper thoracic spine bilaterally is very slightly worse; no change in muscle tightness in thoraco-lumbar spine bilaterally; no change in decreased range of motion in thoraco-lumbar spine bilaterally; no change in muscle tightness in lumbo-sacral spine bilaterally; no change in decreased range of motion in lumbo-sacral spine bilaterally; no change in muscle tightness in hip joint bilaterally.
Assessment: condition is same as last reported
Plan: return in two days
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

9/29/04
Treatment: infrared treatment; therapy performed

10/7/04
Subjective: Pain in neck bilaterally is very slightly worse; pain across shoulders bilaterally is very slightly worse; pain and tingling in arms bilaterally are very slightly worse; no change in light-headedness; no change in pain in ribcage bilaterally; pain in lower back bilaterally is very slightly worse; no change in aching in right ankle; no change in pain in shoulder bilaterally; no change in pain in left knee.
Objective: Muscle tightness in cervical spine bilaterally is very slightly worse; decreased range of motion in cervical spine bilaterally is very slightly worse; muscle tightness in upper thoracic spine bilaterally is very slightly worse; decreased range of motion in upper thoracic spine bilaterally is very slightly worse; muscle tightness in thoraco-lumbar spine bilaterally is very

slightly worse; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly worse; muscle tightness in lumbo-sacral spine bilaterally is very slightly worse; decreased range of motion in lumbo-sacral spine bilaterally is very slightly worse; muscle tightness in hip joint bilaterally is very slightly worse.
Assessment: overall condition is slightly worse
Plan: return in one day
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

10/8/04
Subjective: Pain in neck bilaterally is very slightly improved; no change in pain across shoulders bilaterally; no change in pain and tingling in arms bilaterally; no change in light-headedness; pain in ribcage bilaterally is very slightly improved; pain in lower back bilaterally is very slightly improved; aching in right ankle is very slightly improved; pain in shoulder bilaterally is very slightly improved; pain in left knee is very slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved.
Assessment: overall condition is slightly improved
Plan: return next week
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

10/13/04
Subjective: Pain in neck bilaterally is very slightly improved; no change in pain across shoulders bilaterally; pain and tingling in arms bilaterally are very slightly improved; light-headedness is very slightly improved; pain in ribcage bilaterally is very slightly improved; pain in lower back bilaterally is very slightly improved; aching in right ankle is very slightly improved; no change in pain in shoulder bilaterally; pain in left knee is very slightly improved.

Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; no change in muscle tightness in upper thoracic spine bilaterally; no change in decreased range of motion in upper thoracic spine bilaterally; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved.
Assessment: continues to slowly improve

Plan: return in two days
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

10/15/04
Subjective: Pain in neck bilaterally is very slightly improved; pain across shoulders bilaterally is very slightly improved; pain and tingling in arms bilaterally are very slightly improved; light-headedness is very slightly improved; pain in ribcage bilaterally is very slightly improved; pain in lower back bilaterally is very slightly improved; aching in right ankle is very slightly improved; pain in shoulder bilaterally is very slightly improved; pain in left knee is very slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved.
Assessment: continues to slowly improve
Plan: return next week
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

10/22/04
Subjective: No change in pain in neck bilaterally; pain across shoulders bilaterally is very slightly worse; pain and tingling in arms bilaterally are very slightly worse; light-headedness is very slightly improved; pain in ribcage bilaterally is very slightly improved; pain in lower back bilaterally is very slightly improved; aching in right ankle is very slightly improved; pain in shoulder bilaterally is very slightly worse; pain in left knee is very slightly improved.

Objective: Muscle tightness in cervical spine bilaterally is very slightly worse; decreased range of motion in cervical spine bilaterally is very slightly worse; muscle tightness in upper thoracic spine bilaterally is very slightly worse; decreased range of motion in upper thoracic spine bilaterally is very slightly worse; muscle tightness in thoraco-lumbar spine bilaterally is very slightly worse; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly worse; muscle tightness in lumbo-sacral spine bilaterally is very slightly worse; decreased range of motion in lumbo-sacral spine bilaterally is very slightly worse; muscle tightness in hip joint bilaterally is very slightly worse.
Assessment: overall condition is slightly worse
Plan: return in three days
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

10/26/04
Subjective: Pain in neck bilaterally is slightly improved; pain across shoulders bilaterally is slightly improved; pain and tingling in arms bilaterally are slightly improved; light-headedness is improved; pain in ribcage bilaterally is slightly improved; pain in lower back bilaterally is slightly improved; aching in right ankle is slightly improved; pain in shoulder bilaterally is slightly improved; pain in left knee is slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is improved; decreased range of motion in cervical spine bilaterally is improved; muscle tightness in upper thoracic spine bilaterally is slightly improved; decreased range of motion in upper thoracic spine bilaterally is slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is slightly improved.
Assessment: continues to slowly improve
Plan: return in two days
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

10/28/04
Subjective: No change in pain in neck bilaterally; no change in pain across shoulders bilaterally; no change in pain and tingling in arms bilaterally; light-headedness is slightly improved; no change in pain in ribcage bilaterally; no change in pain in lower back bilaterally; aching in right ankle is very slightly improved; no change in pain in shoulder bilaterally; no change in pain in left knee.
Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; no change in muscle tightness in thoraco-lumbar spine bilaterally; no change in decreased range of motion in thoraco-lumbar spine bilaterally; no change in muscle tightness in lumbo-sacral spine bilaterally; no change in decreased range of motion in lumbo-sacral spine bilaterally; no change in muscle tightness in hip joint bilaterally.
Assessment: flare-ups seen in condition
Plan: return next week
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed

10/29/04
Subjective: Pain in neck bilaterally; pain across tops of shoulders bilaterally; pain in arm bilaterally; numbness in arm bilaterally; headache; dizzy/light-headed; pain in upper back bilaterally; stiffness in middle back bilaterally; pain in lower back bilaterally; pain in left knee; pain in right ankle; pain in hip bilaterally.
Objective: Muscle tightness in cervical spine bilaterally; decreased range of motion in cervical spine bilaterally; muscle tightness in upper thoracic spine bilaterally; decreased range of motion

in upper thoracic spine bilaterally; muscle tightness in thoraco-lumbar spine bilaterally; decreased range of motion in thoraco-lumbar spine bilaterally; muscle tightness in lumbo-sacral spine bilaterally; decreased range of motion in lumbo-sacral spine bilaterally; muscle tightness in hip joint bilaterally; slight swelling on outside of right ankle.
Diagnosis: neck sprain; sprain of unspecified site of shoulder and upper arm; sprain of unspecified site of knee and leg; ankle sprain

11/1/04
Subjective: Pain in neck bilaterally is very slightly worse; pain across tops of shoulders bilaterally is very slightly worse; no change in pain in arm bilaterally; no change in numbness in arm bilaterally; no change in headaches; no change in dizzy/light-headed complaint; no change in pain in upper back bilaterally; no change in stiffness in middle back bilaterally; pain in lower back bilaterally is very slightly worse; no change in pain in left knee; no change in pain in right ankle; pain in hip bilaterally is very slightly worse.
Objective: Muscle tightness in cervical spine bilaterally is very slightly worse; decreased range of motion in cervical spine bilaterally is very slightly worse; muscle tightness in upper thoracic spine bilaterally is very slightly worse; decreased range of motion in upper thoracic spine bilaterally is very slightly worse; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly worse; decreased range of motion in lumbo-sacral spine bilaterally is very slightly worse; muscle tightness in hip joint bilaterally is very slightly worse; no change in slight swelling on outside of right ankle.
Assessment: overall condition is very slightly worse
Plan: return in two days
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed.

11/3/04
Subjective: Pain in neck bilaterally is very slightly improved; pain across tops of shoulders bilaterally is very slightly improved; pain in arm bilaterally is very slightly improved; numbness in arm bilaterally is very slightly improved; no change in headaches; no change in dizzy/light-headed complaint; pain in upper back bilaterally is very slightly improved; stiffness in middle back bilaterally is very slightly improved; pain in lower back bilaterally is very slightly improved; pain in left knee is very slightly improved; pain in right ankle is very slightly improved; pain in hip bilaterally is very slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved; slight swelling on outside of right ankle is very slightly improved.

Assessment: overall condition is very slightly improved
Plan: return in two days
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed.

11/5/04
Subjective: No change in pain in neck bilaterally; no change in pain across tops of shoulders bilaterally; no change in pain in arm bilaterally; no change in numbness in arm bilaterally; no change in headaches; no change in dizzy/light-headed complaint; no change in pain in upper back bilaterally; no change in stiffness in middle back bilaterally; no change in pain in lower back bilaterally; no change in pain in left knee; no change in pain in right ankle; no change in pain in hip bilaterally.
Objective: No change in muscle tightness in cervical spine bilaterally; decreased range of motion in cervical spine bilaterally is slightly improved; muscle tightness in upper thoracic spine bilaterally is slightly improved; decreased range of motion in upper thoracic spine bilaterally is slightly improved; no change in muscle tightness in thoraco-lumbar spine bilaterally; no change in decreased range of motion in thoraco-lumbar spine bilaterally; no change in muscle tightness in lumbo-sacral spine bilaterally; no change in decreased range of motion in lumbo-sacral spine bilaterally; no change in muscle tightness in hip joint bilaterally; no change in slight swelling on outside of right ankle.
Assessment: overall condition is same as last reported
Plan: return next week
Treatment: specific posterior adjustive procedures; cranial manipulation; infrared treatment; therapy performed.

11/8/04
Treatment: ultrasound administered; therapy performed

11/10/04
Subjective: Pain in neck bilaterally is very slightly improved; pain across tops of shoulders bilaterally is very slightly improved; pain in arm bilaterally is very slightly improved; numbness in arm bilaterally is very slightly improved; no change in headaches; no change in dizzy/light-headed complaint; pain in upper back bilaterally is very slightly improved; stiffness in middle back bilaterally is very slightly improved; pain in lower back bilaterally is very slightly improved; no change in pain in left knee; no change in pain in right ankle; pain in hip bilaterally is very slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is very slightly improved; decreased range of motion in cervical spine bilaterally is very slightly improved; muscle tightness in upper thoracic spine bilaterally is very slightly improved; decreased range of motion in upper thoracic spine bilaterally is very slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved; no change in slight swelling on outside

of right ankle.
Assessment: overall condition is very slightly improved
Plan: return in one day
Treatment: specific posterior adjustive procedures; cranial manipulation; manipulation performed on right ankle and right hip join

11/11/04
Treatment: Ultrasound

11/15/04
Treatment: Ultrasound; therapy performed

11/18/04
Treatment: Ultrasound; therapy performed

11/22/04
Assessment: re-examination performed

11/30/04
Treatment: Ultrasound; therapy performed

12/1/04
Subjective: Pain in neck bilaterally is slightly improved; pain across tops of shoulders bilaterally is slightly improved; pain in arm bilaterally is slightly improved; numbness in arm bilaterally is slightly improved; headache condition is slightly improved; dizzy/light-headed condition slightly improved; pain in upper back bilaterally is slightly improved; stiffness in middle back bilaterally is slightly improved; pain in lower back bilaterally is slightly improved; no change in pain in left knee; pain in right ankle is slightly improved; pain in hip bilaterally is slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is slightly improved; decreased range of motion in cervical spine bilaterally is slightly improved; muscle tightness in upper thoracic spine bilaterally is slightly improved; decreased range of motion in upper thoracic spine bilaterally is slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is improved; decreased range of motion in thoraco-lumbar spine bilaterally is improved; muscle tightness in lumbo-sacral spine bilaterally is improved; decreased range of motion in lumbo-sacral spine bilaterally is improved; muscle tightness in hip joint bilaterally is improved; slight swelling on outside of right ankle is improved.
Assessment: continues to slowly improve
Plan: return in one day
Treatment: specific posterior adjustive procedures; cranial manipulation

12/2/04
Treatment: ultrasound; therapy performed

12/6/04

Treatment: ultrasound; therapy performed

12/9/04
Subjective: Pain in neck bilaterally is very slightly improved; pain across tops of shoulders bilaterally is very slightly improved; pain in arm bilaterally is very slightly improved; no change in numbness in arm bilaterally; headache condition very slightly improved; dizzy/light-headed condition very slightly improved; pain in upper back bilaterally is very slightly improved; stiffness in middle back bilaterally is very slightly improved; pain in lower back bilaterally is very slightly improved; no change in pain in left knee; no change in pain in right ankle; pain in hip bilaterally is very slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is slightly improved; decreased range of motion in cervical spine bilaterally is slightly improved; muscle tightness in upper thoracic spine bilaterally is slightly improved; decreased range of motion in upper thoracic spine bilaterally is slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved; no change in slight swelling on outside of right ankle.
Assessment: continues to slowly improve
Plan: return next week
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation; neck stretch.

12/13/04
Treatment: ultrasound

12/16/04
Subjective: Pain in neck bilaterally is slightly improved; pain across tops of shoulders bilaterally is slightly improved; pain in arm bilaterally is slightly improved; numbness in arm bilaterally is slightly improved; headache condition is slightly improved; dizzy/light-headed condition is slightly improved; pain in upper back bilaterally is slightly improved; stiffness in middle back bilaterally is very slightly improved; pain in lower back bilaterally is very slightly improved; pain in left knee is very slightly improved; no change in pain in right ankle; pain in hip bilaterally is very slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is slightly improved; decreased range of motion in cervical spine bilaterally is slightly improved; muscle tightness in upper thoracic spine bilaterally is slightly improved; decreased range of motion in upper thoracic spine bilaterally is slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is slightly improved; muscle tightness in lumbo-sacral spine bilaterally is slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is slightly improved; muscle tightness in hip joint bilaterally is slightly improved; no change in slight swelling on outside of right ankle.
Assessment: continues to slowly improve
Plan: return next week

Treatment: anterior adjustive procedures; specific posterior adjustive procedures; neck stretch; cranial manipulation.

12/21/04
Treatment: Ultrasound; therapy performed

12/27/04
Subjective: Pain in neck bilaterally is very slightly improved; pain across tops of shoulders bilaterally is very slightly improved; pain in arm bilaterally is very slightly improved; numbness in arm bilaterally is very slightly improved; headache condition is very slightly improved; dizzy/light-headed condition is very slightly improved; pain in upper back bilaterally is very slightly improved; stiffness in middle back bilaterally is very slightly improved; pain in lower back bilaterally is very slightly improved; no change in pain in left knee; no change in pain in right ankle; pain in hip bilaterally is very slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is slightly improved; decreased range of motion in cervical spine bilaterally is slightly improved; muscle tightness in upper thoracic spine bilaterally is slightly improved; decreased range of motion in upper thoracic spine bilaterally is slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is slightly improved; muscle tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved; slight swelling on outside of right ankle is very slightly improved.
Assessment: continues to slowly improve
Plan: return in one day
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation.

12/28/04
Treatment: ultrasound; therapy performed

12/30/04
Subjective: Pain in neck bilaterally is slightly improved; pain across tops of shoulders bilaterally is slightly improved; pain in arm bilaterally is slightly improved; numbness in arm bilaterally is slightly improved; headache condition is slightly improved; dizzy/light-headed condition is slightly improved; pain in upper back bilaterally is slightly improved; stiffness in middle back bilaterally is slightly improved; pain in lower back bilaterally is slightly improved; pain in left knee is very slightly improved; pain in right ankle is very slightly improved; pain in hip bilaterally is very slightly improved.
Objective: Muscle tightness in cervical spine bilaterally is slightly improved; decreased range of motion in cervical spine bilaterally is slightly improved; muscle tightness in upper thoracic spine bilaterally is slightly improved; decreased range of motion in upper thoracic spine bilaterally is slightly improved; muscle tightness in thoraco-lumbar spine bilaterally is very slightly improved; decreased range of motion in thoraco-lumbar spine bilaterally is very slightly improved; muscle

tightness in lumbo-sacral spine bilaterally is very slightly improved; decreased range of motion in lumbo-sacral spine bilaterally is very slightly improved; muscle tightness in hip joint bilaterally is very slightly improved; slight swelling on outside of right ankle is very slightly improved.
Assessment: continues to slowly improve
Plan: return next week
Treatment: anterior adjustive procedures; specific posterior adjustive procedures; cranial manipulation.

1/10/05
Assessment: re-examination performed
Plan: refer for physical therapy; see doctor regarding blood pressure

Discharge Summary, Sayeed Ahmed MD, City Hospital, 2/28/05 (Tr. 321-322)
Final Diagnosis: gastrointestinal bleed, secondary to gastric ulcer and duodenitis; anemia, iron deficiency, probably secondary to first diagnosis; obesity; mild hypertension.
Discharge Medications: Protonix
Discharge Instructions: lose weight; cut salt intake

History and Physical,, Sayeed Ahmed, MD, City Hospital, 2/23/08 (Tr. 323-324)
Chief Complaint: blood in stool
Impression: gastrointestinal bleed, probably most likely lower gastrointestinal bleed; history of heavy menstrual periods; anemia, iron deficiency, probably secondary to first two causes; obesity; mild hypertension.
Plan: admit; clear liquid; surgical consult

Consultation Report, Timothy Bowers Jr., MD, City Hospital, 2/23/05 (Tr. 325-326)
Assessment: acute upper gastrointestinal hemorrhage
Plan: rest, IV hydration, serial hematocrit; recommend blood transfusion on as needed basis

Emergency Room Note, David Ebbitt, MD, City Hospital 2/23/05 (Tr. 237-328)
Chief Complaint: vomiting blood; black stools
Assessment: upper gastrointestinal bleed; anemia

Operative Note, Sayeed Ahmed, MD, City Hospital, 2/27/05 (Tr. 239-330)
Preoperative Diagnosis: upper gastrointestinal hemorrhage
Postoperative Diagnoses: gastric ulcer; duodenitis
Procedure: Esophagogastroduodenoscopy with biopsy

Diagnostic Radiology Report, Hojoon Jung, MD, City Hospital, 2/24/05 (Tr. 336)
Evaluation of esophagus demonstrates no ulcerations or strictures. No reflux noted during study. Fold pattern and mucosal appearance of stomach is within normal limits
Duodenal bulb opens normally.
Impression: unremarkable barium upper GI and small bowel study

Psychological Evaluation, Harold Slaughter, Jr., M.S., 9/9/05 (Tr. 338-342)

WAIS-III scores yielded a Full Scale IQ of 71
- Verbal IQ = 71
- Performance IQ = 76
- placed in Borderline (slow-learner) range of Intellectual functioning
- scores are consistent with results from previous evaluation (7/13/01)

Achievement Testing (WRAT-3)
- Reading at high school level
- Math at sixth grade level
- standard scores of 93 and 81 respectively
- results are consistent with previous evaluation

attention and concentration are mildly impaired (Comprehension Subtest Score = 5)
recent memory is mildly impaired
no indications of major emotional issues such as hallucinations, delusions, etc.
no indications of suicidal or homicidal ideation, intention, or plan

Diagnosis (DSM-IV):
- Axis I 309.0 Adjustment Disorder with Depressed Mood
- Axis II V62.89 Borderline Intellectual Functioning
- Axis III High Blood Pressure; myositis; Myalgia; Osteoarhritis
- Axis IV None
- Axis V GAF = 65 (current)

functioning at Borderline (slow-learner) range of intelligence

Gyncytology Report, Stuart Monroe, MD, 11/7/01 (Tr. 385)

Descriptive Diagnosis: cytologic findings WITHIN NORMAL LIMITS

Gyncytology Report, Stuart Monroe, MD, 7/6/00 (Tr. 389)

Descriptive Diagnosis: cytologic findings WITHIN NORMAL LIMITS

Gyncytology Report, Stuart Monroe, MD, 4/22/99 (Tr. 392)

Descriptive Diagnosis: benign cellular changes, Trichomonas vaginalis; cytologic findings WITHIN NORMAL LIMITS

Mammography Report, Martin Fleming, MD, 7/26/00 (Tr. 397)

Bilateral Screening Mammogram: intramammary lymph nodes in axillary tails of both breasts; both breasts appear otherwise normal.
Impression: Bi-Rads Category 2: Benign Findings

Radiology Report, D. Misailidis, MD, 1/20/99 (Tr. 398)

Right and Left Shoulder: no asymmetry of the AC joints. Glenohumeral and AC articulation are normal.
Impression: normal right and left shoulder

Radiology Report, D. Misailidis, MD, 1/20/99 (Tr. 399)

AP and Lateral Cervical Spine: C1 to C7 are visualized and there is good alignment of the

anterior and posterior column. Prevertebral soft tissues are normal in size. No loss of vertebral height.
Impression: normal cervical spine

Radiology Report, D. Misailidis, MD, 1/20/99 (Tr. 400)
AP and Lateral Thoracic Spine: no fracture, dislocation or bone destruction is seen. The disc spaces are well maintained.
Impression: normal thoracic spine

Radiology Report, D. Misailidis, MD, 1/20/99 (Tr. 401)
AP and Lateral Lumbar Spine: no fracture, dislocation, or bone destruction is noted. Interspaces and apophyseal spaces are well maintained. Osseous architecture is unremarkable.
Impression: normal lumbar spine

Mammography Report, Christopher Ladd, MD, 5/19/99 (Tr. 402)
Breasts are appropriately dense for patient's age. No suspicious mass, calcification cluster, or an area of architectural distortion.
Impression: no mammographic evidence of malignancy
Bi-Rads Category 2: Benign Finding

Consultative Evaluation Report, Randolph MacDonald, ED.D., 4/10/06 (Tr. 405-408)
Assessments Completed:
mental status examination (MSE)
clinical interview (CI)
General Observations: arrived early; casually and neatly dressed
Chief Complaints: joint pain, left leg pain, arm, shoulder, neck, and lower back pain. Has a bleeding gastric ulcer; is depressed
Presenting Symptoms: sleeps a lot; healthy appetite; gained weight over past six months; experiences crying episodes; energy level is low; experiences panic attacks. Not suicidal, nor does she have suicidal thoughts
Mental Status Examination: oriented x4. Speech was within normal range and pace. Mood was described as depressed; affect was broad; thought content seemed clear. Cognitive capability was probably somewhat below average based on assessment by Mr. Slaughter in September of 2005. Insight seemed fair; judgment is fair. Immediate memory is good; was able to recall four words immediately after having them read to her. Within twenty minutes, could not recall any of them, so recent memory is poor. Concentration is poor. Tried to do serial threes, but made several mistakes on the way down after reaching the upper 80s.
Social Functioning During the Evaluation: somewhat guarded, but responded to each question.
Diagnosis:

Axis I	309.0	Adjustment Disorder with Depressed Mood
Axis II	V62.89	Borderline Intellectual Functioning
Axis III		high blood pressure, Myalgia, Osteoarthritis, Myositis

Diagnostic Rationale:
Axis I primarily based on history and report written by Hal Slaughter

Axis II also came from report by Hal Slaughter in which her Full Scale was 71 on the WAIS
Axis III by the medications and by history

Internal Medicine Examination, Susan Garner, MD, 4/5/06 (Tr. 409-415)
Chief Complaint: joint pains, high blood pressure, bleeding gastric ulcer
Physical Examination: general, vital signs, heent, neck, chest, cardiovascular, abdomen, extremities, skin, musculoskeletal, cervical spine, arms, hands, knees, ankles/feet, lumbosacral spine/hips, neurologic

Impression: chronic lumbar pain, probable degenerative disk disease; cervical neck pain, probable degenerative disk disease; polyarthralgias involving the elbows, shoulders, left knee, and right ankle; history of bleeding gastric ulcer, now asymptomatic

Summary: 46 year-old female; injured low back and neck three or four years ago. Tenderness over spinous processes from lower thoracic to the lower lumbar segment. Gluteal muscle tenderness on right and left, but no spasm. Could flex forward and to the sides. Positive straight leg raise test bilaterally. Walked with normal gait and did not require ambulatory assistance device. Comfortable seated and while lying supine. Could arise from a seated to a standing position and step up and down from the examination table. Could heel-walk, toe-walk, and heal-to-toe walk, and squat without difficulty. No tenderness over spinous processes of the cervical spine. Could flex, extend, and rotate at the neck without difficulty. No tenderness, warmth, crepitation, or swelling of the elbows. Able to flex and extend elbows without difficulty. No tenderness or crepitation over the shoulder. Could not flex or extend past 90 degrees on the left. Could internally and externally rotate without difficulty at both shoulders. No crepitation or swelling in knees. Could flex and extend without difficulty bilaterally. No tenderness over ankles; no swelling. Able to dorsi and plantarflex at ankles bilaterally with no restrictions. Abdominal examination revealed no tenderness, rebound, or guarding. No intraabdominal masses appreciated. Abdomen was nondistended. Normal bowel sounds.

Diagnostic Radiology Report, John Blanco, MD, 4/5/06 (Tr. 418)
lumbar spine- three views: mild multi-level degenerative disc disease of the lumbar spine with mild disc space narrowing at L5-S1 and small anterior osteophytes at L3 and L4. No fracture or subluxation.
Impression: mild degenerative disc disease of the lower lumbar spine

Physical Residual Functional Capacity Assessment, Michael Mick, 4/24/06 (Tr. 419-426)
Exertional Limitations
occasionally lift and/or carry up to 20 pounds
frequently lift and/or carry up to 10 pounds
stand and/or walk (with normal breaks) for a total of about 6 hours in an 8-hour workday
sit (with normal breaks) for a total of about 6 hours in an 8-hour workday
push and/or pull (including operation of hand and/or foot controls) - unlimited, other than as shown for lift and/or carry

Postural Limitations
climbing ramp/stairs occasionally
climbing ladder/rope/scaffolds never
balancing frequently
stooping occasionally
kneeling occasionally
crouching occasionally
crawling occasionally
Manipulative Limitations
reaching all directions (including overhead) limited
handling (gross manipulation) unlimited
fingering (fine manipulation) unlimited
feeling (skin receptors) unlimited
Visual Limitations
none
Communicative Limitations
none
Environmental Limitations
extreme cold avoid concentrated exposure
extreme heat avoid concentrated exposure
wetness unlimited
humidity unlimited
noise unlimited
vibration avoid concentrated exposure
fumes, odors, dusts, gases, poor ventilation avoid concentrated exposure
hazards (machinery, heights, etc.) avoid concentrated exposure
Severity of Symptoms and Consistency with Medical and Nonmedical Evidence
ADLS walks and exercises daily, ADLS states short of breath, but no notes in reports. ADLS states hard to kneel but report states able to squat without difficulty. Some distinct inconsistencies reported by the Claimant in different vinues-CE report vs. ADLS report. Objective findings do not support the subjective complaints. Claimant is not fully credible
Treating or Examining Source Statements
ALJ June 2000 - sedentary, no lift and carry more than 10 pounds, stand or walk prolonged periods. Does not like to be around people
ALJ July 27, 2002 - severe physical and psychological impairments, does not meet or equal listings, credible, less than sedentary. Disabled since 7/14/00
December 26, 2002 - not eligible due to excessive income and resources, decision dated 11/28/03

Psychiatric Review Technique, Joseph Shaver, Ph.D, 4/24/06 (Tr. 427-441)
Medical Summary
RFC Assessment Necessary
Medical Disposition Based on: 12.02 Organic Mental Disorders and 12.04 Affective Disorders
Documentation of Factors that Evidence the Disorder

12.02 Organic Mental Disorders: BIF disorder
12.04 Affective Disorders: Adjustment Disorder with Depressed Mood
Rating of Functional Limitations
restriction of activities of daily living: mild
difficulties in maintaining social functioning: mild
difficulties in maintaining concentration, persistence, or pace: moderate
episodes of decompensation, each of extended duration: none

Mental Residual Functional Capacity Assessment, Joseph Shaver, Ph.D., 4/24/06 (Tr. 441-444)
Summary Conclusions
ability to remember locations and work-like procedures: not significantly limited
ability to understand and remember very short and simply instructions: not significantly limited
ability to understand and remember detailed instructions: moderately limited
ability to carry out very short and simple instructions: not significantly limited
ability to carry out detailed instructions: moderately limited
ability to maintain attention and concentration for extended periods: moderately limited
ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances: not significantly limited
ability to sustain an ordinary routine without special supervision: not significantly limited
ability to work in coordination with or proximity to others without being distracted by them: not significantly limited
ability to make simple work-related decisions: not significantly limited
ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods: moderately limited
ability to interact appropriately with the general public: not significantly limited
ability to ask simple questions or request assistance: not significantly limited
ability to accept instructions and respond appropriately to criticism from supervisors: not significantly limited
ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes: not significantly limited
ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness: not significantly limited
ability to respond appropriately to changes in the work setting: not significantly limited
ability to be aware of normal hazards and take appropriate precautions: not significantly limited
ability to travel in unfamiliar places or use public transportation: not significantly limited
ability to set realistic goals or make plans independently of others: not significantly limited
Functional Capacity Assessment
Early WAIS placed Claimant's FSIQ at 70-71. MSE (4/10/06) showed that Clmt was cooperative and oriented x4. Her mood was described as depressed while her affect was broad. Recent memory and concentration were rated as poor. Thought content, insight, judgment, and immediate/remote memory fell WNL.

Axis I: Adjustment Disorder with Depressed Mood

Axis II: BIF

Clmt does housework, prepares meals, pays bills, handles finances, and attends church occasionally. She appears to be generally credible regarding her reported mental functioning. It is believed that Clmt retains the mental capacity operate in routine work situations that require two to three step operations.

Physical Residual Functional Capacity Assessment, Fulvio Franyutti. MD, 9/25/06 (Tr. 445-452)

Exertional Limitations

occasionally lift and/or carry up to 20 pounds
frequently lift and/or carry up to 10 pounds
stand and/or walk (with normal breaks) for a total of about 6 hours in an 8-hour workday
sit (with normal breaks) for a total of about 6 hours in an 8-hour workday
push and/or pull (including operation of hand and/or foot controls) - unlimited, other than as shown for lift and/or carry

Postural Limitations

climbing ramp/stairs occasionally
climbing ladder/rope/scaffolds occasionally
balancing occasionally
stooping occasionally
kneeling occasionally
crouching occasionally
crawling occasionally

Manipulative Limitations

none

Visual Limitations

none

Communicative Limitations

none

Environmental Limitations

extreme cold avoid concentrated exposure
extreme heat avoid concentrated exposure
wetness unlimited
humidity unlimited
noise unlimited
vibration avoid concentrated exposure
fumes, odors, dusts, gases, poor ventilation avoid concentrated exposure
hazards (machinery, heights, etc.) avoid concentrated exposure

Severity of Symptoms and Consistency with Medical and Nonmedical Evidence

Claimant appears to be partially credible.

Additional Comments

At CE, her lungs were clear; however, on 6/21 she had been coughing up mucus and there was rhonchi in her lungs. The rest of her exam was WNL.

Open MRI, Andrew Sonin, MD, 6/6/01 (Tr. 454)

Findings

Diffuse thickening of the distal cuff consistent with tendinopathy, but there is no full thickness tear, retraction, or atrophy of cuff musculature. Biceps tendon and glenoid labrum are intact. Minimal hypertrophy of acromioclavicular joint. Small subchondral cyst is seen laterally in humeral head. Small amount fluid in subacromial subdeltoid bursa consistent with bursitis. Glenohumeral joint contains a physiologic amount of fluid. No mass.

Conclusion

rotator cuff tendinopathy and minimal subacromial subdeltoid bursitis

Medical Assessment of Ability to do Work-Related Activities (Physical), Michael Rezaian, MD, 11/2/01 (Tr. 455-457)

lifting/carrying affected by impairment
- x-rays and calcific tendonitis
- elevated ESR
- seronegative rheumatoid arthritis

standing/walking affected by impairment
- sacroiliac joint inflammation
- seronegative rheumatoid arthritisaffecting lower extremity joints

sitting is affected by impairment
- sacroiliac joint inflammation
- needs cushion for posture

ability to perform postural activities

climb	frequently
balance	frequently
stoop	frequently
crouch	frequently
kneel	frequently
crawl	frequently

physical functions affected by impairments
- reaching
- handling
- pushing/pulling

environmental restrictions caused by impairments
- heights
- moving machinery
- temperature extremes
- humidity
- vibration

James Dodd, DPM, 8/14/07 (Tr. 485)

Complaint: "I hate the way my toenails look." Pain and discomfort from toenails; discolored and had fungus. Depressed about look.

Plan: reviewed risks and complications, including live failure; discussion concerning treatment

options

Medical Records, R.L. Rauch, DPM, 7/7/00 - 6/3/08 (Tr. 500-509)

6/3/08
Complaint: toenails are long, thick, and painful
Objective: skin TTT is WNL. Onychomyeosis is noted 1 - 10 - all 10 nails are painful, thick, crumbly, and discolored.
Assessment: Onychomycosis 1-10
Treatment: debride and byrr mycotic nails 1-10, curette free debris. Return in three months

3/4/08
Complaint: needs toenails trimmed
Objectively: skin TTTI are WNL. Onychomycosis noted 1-10 - all 10 nails are painful, thick, crumbly, and discolored. IS are clean and dry, no plantar lesions are noted
Assessment: Onychomycosis 1-10
Treatment: debride and burr mycotic nails 1-10, curette free debris; return in three months.

12/12/01
Complaint: long, thick, painful toenails that need trimmed.
Objectively: Onychomycosis 1 - 10 - all nails are thick, crumbly, discolored, painful to the touch
Assessment: Oncyhomycosis 1 - 10. Continue with Lamisil therapy
Treatment: LFT; return in 6 weeks for follow up

11/28/01
Complaint: painful in-growing medial and lateral borders hallux B/L. Very sore.
Objectively: onychomycotic hallux nails B/L with cryptotic medial and lateral border same. No S/S of infection.
Assessment: Cryptotic medial and lateral border hallux nail B/L with onychomycosis same
Treatment: debride and burr hallux nails, excised offending portion of nails medial and lateral border, curette free debris. Return on regularly scheduled appointment.

10/31/01
Complaint: follow up evaluation of Onychomycosis; is some clearing in fingernails but not much in toenails.
Objectively: Onychomycosis 1 - 10 - all nails are thick, crumbly, discolored, painful to the touch. Fingernails show some clearing of Onychomycosis.
Assessment: Onychomycosis 1 - 10
Treatment: debride and burr mycotic nails 1 - 10, curette free debris.

9/21/01
Complaint: continued care of thick toenails
Objectively: Onychomycosis 1 - 10; thick, crumbly, discolored, painful to the touch
Assessment: Onychomycosis 1 - 10 and fingernails 1 - 10
Treatment: debride and burr mycotic toenails 1 - 10, curette free debris. Dressed 2nd L with TAO

and DSD.

8/8/01
Complaint: fungus in her fingernails; thick and long
Objectively: Onychomycosis 1 - 10 in both toenails and fingernails - thick, crumbly, discolored, painful to the touch
Assessment: Onychomycosis 1 - 10 as well as fingernails 1 - 10. Recommend Lamisil therapy.
Treatment: debride and burr mycotic nails 1 - 10, curette free debris; return in six weeks for follow up

6/21/01
Complaint: concern of painful ingrown medial border hallux nails B/L.
Objectively: Onychomycosis medial borders hallux B/L. Painful; no S/S of infection
Assessment: Cryptotic medial border hallux nails B/L
Treatment: excised offending portion of nail medial borders hallux B/L, curette free debris. Debride and burr nails as well

5/21/01
Complaint: long, thick, and painful toenails
Objectively: Onychomycosis 1 - 10; nails are thick, crumbly, discolored, painful to the touch. Onychomycosis hallux nails bilaterally
Treatment: debride and burr mycotic nails 1 - 10, curette free debris. Return in three months

3/12/01
Complaint: long, thick, painful toenails
Objectively: Onychomycosis 1 - 10 - all 10 nails are thick, crumbly, discolored, painful to touch
Assessment: Onychomycosis 1 - 10
Treatment: debride and burr mycotic nails 1 - 10, curette free debris

1/30/01
Complaint: follow up evaluation of long, thick, painful toenails. Heel callus heels B/L
Objectively: Onychomycosis 1 - 10 - all nails are thick, crumbly, discolored, painful to touch. Heel callus B/L, not as severe as before. Areas are tender but not painful. No S/S of infection.
Assessment: Onychomycosis 1 - 10; heel callus heels B/L
Treatment: debride and burr mycotic nails 1 - 10, curette free debris. Debrided heel callus heels B/L, SDS. Return in ten weeks.

12/11/00
Complaint: long, thick, painful toenails need trimmed; heel callus
Objectively: Onychomycosis 1 - 10 - all nails are thick, crumbly, discolored, painful to touch. Minor heel callus heels B/L medial plantar aspect of both heels. Areas are tender to touch, but not painful. No S/S of infection.
Assessment: Onychomycosis 1 - 10; heel callus medial plantar aspect of heels B/L
Treatment: debride and burr mycotic nails 1 - 10, curette free debris. Debrided heel callus heels

B.L. Return in ten weeks.

10/23/00
Complaint: follow up evaluation of lateral heel pain; long and thick nails need trimmed
Objectively: Onychomycosis nails 1 - 10 - all nails are thick, crumbly, discolored, painful to touch. Mild dry skin noted medial aspect heels B/L. Heels are not painful.
Assessment: Onychomycosis 1 - 10; continue with Vioxx
Treatment: debride and burr mycotic nails 1 - 10, curette free debris. Return in ten weeks for continued care or sooner if heels flare up

10/6/00
Complaint: evaluation of B/L heel pain; feet are extremely sore and painful
Objectively: no real pain could be elicited upon palpation medial plantar aspect heels. Large amount of hyperkeratotic heel callus buildup
Assessment: questionable relief from Motrin
Treatment: continue on Vioxx

9/20/00
Complaint: follow-up evaluation of B/L heel pain.
Objectively: mild tenderness upon palpation medial plantar aspect heels B/L, not as severe as before. Onychomycosis 1 - 10 - all nails are thick, crumbly, discolored, painful to touch.
Assessment: plantar fascitis/heel pain feels B/L; Onychomycosis 1 - 10
Treatment: debride and burr mycotic nails 1 - 10, curette free debris; return in two weeks

8/14/00
Complaint: follow-up evaluation of B/L heel pain
Objectively: mild tenderness upon palpation medial plantar aspect heels B/L. Large amount of hyperkeratotic dry skin noted; no increase in temperature, no erythema or edema noted.
Assessment: recalcitrant heel pain
Treatment: continue on Celebrex

7/18/00
Complaint: follow-up evaluation of heel pain heels B/L. Patient walks for weight control and to keep joints loosened up. Feet are not bothering her.
Objectively: no pain could be elicited upon palpation; no erythema, no edema noted.
Assessment: missed the window of pain for patient
Treatment: continue with Celebrex, ice/warm, moist compresses, stretching exercises

7/7/00
Complaint: achy pain in both heel areas - medial plantar aspect only for first 3 days of her monthly menstrual cycle. Feet are painful; can't stay on them; must keep them elevated. Secondary concern of Onychomycosis 1 - 10.
Objectively: skin texture, turgor, and temperature within normal limits. Onychomycosis 1 - 10 -

all nails are thick, crumbly, discolored, and painful to touch. Mild heel callus medial plantar aspect of heels B/L. Heels themselves are not painful medial plantar aspect. No erythema or edema noted.
Diagnosis: Onychomycosis 1 - 10; vague diffuse heel pain, but not painful today.
Treatment: H&P; debrided and burred mycotic nails 1 - 10, curette free debris; debrided heel callus, SDS. Return in three weeks when heels become painful.

Medical Record, John Draper, MD, 4/3/07 - 5/7/08 (Tr. 510-513)

5/7/08
Complaint: weight gain. Shoulders hurt; although, injections are helping. Terrified of surgery. Left knee trembles; no effusion in the knees and no instability.
Medical Decision: possible internal derangement left knee
Plan: MRI of knee

2/27/08
Complaint: temporary relief from injection of left shoulder. Abduct and forward flex to only 90 degrees. Some symptoms in right shoulder, but able to get it through a full ROM. Back pain
Medical Decision: possible rotator cuff tear left shoulder
Plan: MRI of left shoulder

1/30/08
Complaint: diagnosed with rheumatoid arthritis by Dr. Rezaian. Pain in both shoulders; left is worse than right. No gross atrophy or deformity of either shoulder. Pain with abduction and forward flexion on both shoulders; can get to about 90 degrees. Subacromial crepitus in left shoulder. Nothing to suggest cervical radiculopathy. Other joints hurt also.
Medical Decision: chronic impingement left shoulder
Plan: corticosteroid injection - skin infiltrated with 1% Lidocaine and subacromial space injected with 40 mg DepoMedrol and 4 cc of 1% Lidocaine

4/27/07
Complaint: right shoulder is feeling better; wants left shoulder injection
Treatment: left shoulder infiltrated with 1% Lidocaine and subacromial space injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine

4/3/07
Complaint: pain in neck, shoulders, rib cage, knees, right ankle
Physical Exam: Pain with abduction and forward flexion of both shoulders. Some crepitus in both knees but has a good ROM and no instability. Good motion of right ankle; no instability on inversion or eversion
Medical Decision: impingement both shoulders; bilateral knee pain; right ankle pain
Plan: injection in right shoulder - skin infiltrated with 1% Lidocaine; subacromial space injected with 40 mg DepoMedrol and 1 cc of 1% Lidocaine

MRI Examination of Left Shoulder, Robert Boutin, MD, 3/25/08 (Tr. 514)

Findings
Musculotendinous Structures: mild-moderate rotator cuff tendinopathy centered in distal supraspinatus tendon with small punctate focus of low signal at interface of supraspinatus bursal-sided fibers and the overlying subdeltoid bursa. Subtle irregular high signal at adjacent supraspinatus tendon bursal surface. No full-thickness rotator cuff tear detected. No biceps tendon tear or displacement detected. No muscle atrophy or edema detected.
Coracoacromial arch: acromion has generally curved configuration, with subtle subacromial osseous ridging. Mild AC joint arthrosis/hypertrophy. Trace fluid in subacromial-subdeltoid bursa and glenohumeral joint
Glenohumeral Joint: no substantial osteophytosis, fracture, or mass lesion detected. Slight subcortical pitting/cystic change at the margin of humeral head. No definite labral tear demonstrated.
Conclusion:
rotator cuff tendinopathy most prominent in supraspinatus, with superficial fraying/irregularity and suggestion of very small, subtle calcification. No full-thickness rotator cuff tear, substantial bursal fluid collection, or fracture detected.
Mild AC joint arthrosis and subtle subacromial osseous ridging

Magnetic Resonance Imaging Report, Hojoon Jung, MD, 6/16/08 (Tr. 515)
Exam: MRI Knee LT WO/Contrast
Findings: anterior and posterior cruciate ligaments are intact. Collateral ligaments are intact. Evaluation of medial and lateral menisci demonstrates no evidence for meniscal tear. Evaluation of articular cartilage demonstrates moderate diffuse cartilage loss in medial compartment. No significant joint effusion.
Impression: moderate cartilage loss in medial compartment, consistent with osteoarthritis. No evidence for meniscal tear or ligamentous tear.

Rural Outreach Arthritis Center, Michael Rezaian, 4/13/07 - 4/14/08 (Tr. 520-532)
4/14/08
Subjective: shoulder pain; difficulty sleeping at night.
Impression/Treatment Plan:
- Fibromyalgia - getting worse with increase in symptomatology
- back pain - no change
- Osteoarthritis of knees - remains same
- Trochanteric Bursitis - remains same
- shoulder pain - Bursitis remains cause of shoulder pain, without change
- Depression - on Cymbalta
- Dysprea - stable on Inhaler
- Overall - remains without change

Physical Exam:
- skin: no rash; warm and dry
- Heent: Sclera is anicteric. No, mouth and throat are clear.
- Lungs: clear to auscultation
- Heart: with regular rate and rhythm. No murmur, rub, or gallops.

1/14/08

Subjective: pain and stiffness in both shoulders, lower back, both knees; difficulty standing and walking; difficulty sleeping.

Impression/Treatment Plan:

Fibromyalgia - remains same
back pain - structural problem and inflammatory process
Osteoarthritis of knees - increase in joint pain and swelling
Trochanteric Bursitis - getting worse
Subacromial Bursitis - cause of shoulder pain and getting worse
Depression: on Cymbalta
Dysprea: stable on Inhaler
Overall: remains same

Follow-up: call if experience symptoms or side effects while on treatment; return in four months

9/11/07

Subjective: pain all over in both upper and lower extremity joints and back. Difficulty sleeping

Impression/Treatment Plan:

Fibromyalgia - remains problematic; difficult to tell if improving because symptoms and exam remain same
Depression - on Cymbalta
Trochanteric Bursitis - cause of hip pain
Subacromial Bursitis - cause of shoulder pain; difficulty lifting arm
Osteoarthritis of knees - cause of some current complaints
Dysprea - cause is not clear
chronic back pain - most likely caused by inflammatory process and structural problems

6/14/07

Subjective: pain, stiffness, and swelling in lower back and hips are getting worse; difficulty sleeping

Impression/Treatment Plan:

Spondyloarthropathy: pain and stiffness remains same
Fibromyalgia: pain and stiffness remains same
Sacroiliac joint inflammation: remains active
trochanteric Bursitis: remains same
fatigue: call if becomes worse
Overall: remains same

Follow-up: call if experience more symptoms or side effects. Return in one month.

4/13/07

Impression: Seronegative Spondyloarthropathy with secondary Fibromyalgia

Plan: Darvocet; no need for additional evaluation or treatment unless condition does not improve in a few weeks

Diagnostic Radiology Report, Hojoon Jung, MD, 5/7/08 (Tr. 533)
Exam: DX Chest PA & LAT
Chest: Cardiovascular silhouette is normal in size and configuration; lungs appear clear; no pleural fluid is noted
Impression: normal chest

D. Testimonial Evidence

Testimony was taken at a hearing held on July 15, 2008. The following portions of the testimony are relevant to the disposition of the case:

Q You're on Tramadol still?

A Yes.

Q How often do you take it? Three times a day?

A Yes.

Q How long can you sit?

A Not long, sir.

Q That doesn't answer. Once - - you have to get up once an hour?

A Like - -

Q Twice?

A Maybe like 20 minutes. It depends when the pains hit me, which is frequently.

Q Where is your pain located?

A Through my shoulders, my arms, my arm sockets, my upper and lower back, down below my rear end, my hips and going down my legs.

Q How would you rate that pain on a scale of zero to 10?

A I'm going to say about a four.

Q Okay. Is your blood pressure under control?

A At times.

Q Well, if you're taking - - has the doctor - - Dr. Hahn quit the medication?

A Yes. But I still got a lot of pain in me. A lot of stressful times. I'm depressed.

Q Well, we'll get to that in just a minute. How long can you stand?

A Maybe about 15 to 20 minutes.

Q How long can you walk?

A It depends on when the pains are going through me.

Q How long can you walk?

A Walking I take a lot - - I'm going to say maybe five, 10 minutes. I'm short of breath.

Q Why are you short of breath?

A I guess because all the anxiety and the depressions I been through. Like I said, I get very, very tired and sleepy because all the 10 medications that I'm on.

Q When did you last work? Was it restaurant work?

A No. It was keying. Data entry.

Q How long ago did you do data entry work?

A That was back like about 1996.

* * *

Q Okay. What would prevent you today - - let's say you get full health benefits and a decent wage and they simply wanted you to do some data entry work. What would interfere with your ability to do that kind of work again?

A Because when the pains hit me I sleep a lot during the day. I'm very tired. I get

frustrated. Remaining calm and mainly it's the pains that going through me for all the lifting that I have done taking care of my invalid mother for years from 1992 to 2004. And she was an extremely large woman.

Q Okay. Have you had any psychiatric hospitalizations?

A Yes, I have.

Q How many psychiatric hospitalizations have you had?

A I had went to - - I went to see a psychiatrist. I went for group counseling and I also seen a - -

ALJ Hospitalization.

ATTY Have you been hospitalized for psychiatric problems?

CLMT No, I went on my own to get help and then I was referred to get help.

ATTY Okay. Have you ever stayed overnight in the hospital for psychiatric reasons?

CLMT No.

* * *

Q Okay. How often do you see a doctor for your physical ailments? That would be Dr. Hahn.

A Once a month. He's my primary doctor.

Q Okay. And he checks your blood pressure. What else does he do?

A He checks with this little tool he uses to hit my arms and my knees and whatnot and my medication.

Q All right. You said breathing problems. Have you had any hospitalizations for

respiratory problems?

A Well, I was in the hospital in February of 2005. That's when they found I had a bleeding gastric ulcer, and I needed a blood transfusion.

Q Okay. What do you find more disabling in terms of affecting your ability to do things around the house, the anxiety or the depression?

A Both.

Q Both of them are equal?

A Yes.

Q Okay. Do you have panic attacks?

A Yes.

Q How often?

A I would say anywhere from two to three days.

Q They occur every two or three days?

A Somewhere around that area. I have bad nightmares.

Q How long do they last?

A Well, my sleeping is off.

Q How long does a panic attack last?

A Fifteen minutes maybe.

Q How often are you visiting Dr. Rezaian?

A Anywhere from two to three months.

* * *

Q Okay. Do you have any memory disturbances?

A Yes.

Q Can you give me an example?

A Well, I can get forgetful.

Q Do you forget to take your medicine?

A Yes, I have.

Q Forget to put gas in the car, or do you run out of gas?

A No, I have not run out of gas. I've been very low and close to it.

* * *

Q Okay. All right. Let's say - - you told me if you had a job that it's too painful and you affect multiple joints and you sleep a lot. How much do you sleep a lot?

A Nighttime - - morning times I can sleep late and also having a nap in the afternoon because the medication does make me drowsy. And I'm careful when I have to go somewhere to drive the car when I take my medication.

Q So let's change the job. Let's just say you have a job just opening the gate for people coming in and out of a parking lot. What would interfere with your ability to do that day in and day out? You see the ID on the front windshield. You got - - you can alternate between sitting and standing every 20 minutes for sure. What would interfere with your ability to do that?

A Because when the rheumatism pain goes through me sometimes I do have to lay down. I can't even be down even to kneel, and I get short of breath and the pains go through me through my arm sockets down, down my back, down to my lower hips and my legs. And then sometimes it might start in different areas.

Q Okay. Well, how were you able to take care of mom with all these problems? Physical problems.

A Well, I was burning myself out. And you can just see it.

Q Okay.

A Even when I asked - -

Q All right.

A - - for help I was denied help and they were still billing her.

Q Do you get along with - - I think I asked this but I'm going to ask it again. Do you get along with people? Do you belong to any social organizations or support group?

A I had went to church. I have friends. Everybody in the community knows what happened.

Q Well, how often do you go to church then?

A Not as often as I should.

ATTY That's not an answer. How often do you go to church?

CLMT Maybe once in a month, but I do watch the gospel programs.

* * *

Q Okay. In terms of treatment for all these physical problems, do you wear a brace or appliance?

A I have to have a posture pillow. I've been in two car accidents.

Q Any litigation - -

A But - -

Q - - as far as that?

A Well, it's for the pressure on my back when the car hit me. And I go to a - -

Q No, any - -

A - - chiropractor. I don't understand.

* * *

Q Okay. Any recommendations for surgery anywhere in your body?

A It has been recommended I have surgery in my left arm, but I'm scared to death of being - -

Q What's wrong - -

A Excuse me?

Q What's wrong with your left arm?

A It's torn ligaments and around the rotary cuff. He suggested that I have surgery, but I'm scared of being cut on.

Q With your depression - - just a few more follow up questions. Do you have crying spells?

A Yes.

Q How often?

A It's not as bad as it used to be but I do have them. It used to be very bad at one time.

ATTY How often?

ALJ Well - - go ahead, Counsel.

ATTY How often do you have them now?

CLMT Twice a week.

BY ADMINISTRATIVE LAW JUDGE:

Q Do you have suicidal thought?

A I have, yes.

Q Any acting out on it?

A No.

Q Are there Cymbalta you're taking helping? Is it worse, same or better than it was two years ago?

A It depends on you know, what I'm going through. And right now with me living out of my car being homeless it's just tearing me apart along with the pains that I'm going through. And sleeping here, sleeping there.

Q There's a reference in the past to rheumatoid arthritis. Have you been diagnosed with rheumatoid?

A Not rheumatoid but arthritis when I was like about 11 or 12.

Q Okay.

A In my knees.

* * *

ATTY Okay. How tall are you? Answer - - I'll ask the question.

ALJ About 5'3".

CLMT 5'3".

ALJ Is that right?

CLMT Yes, sir. 5'3".

ATTY How much do you weigh?

ALJ And you still at 261?

CLMT I've lost a little. I'm not that much.

ATTY Are you about - - how much do you weigh?

CLMT We'll say about 260, 261 then, yes.

ATTY Okay.

ALJ Go ahead, Counsel.

EXAMINATION OF CLAIMANT BY ATTORNEY:

Q Where is your pain exactly?

A Up around like my neck. Down around my shoulders. Definitely around my arms sockets. And the go down to my elbow.

Q On both sides or one side?

A Both sides.

Q Okay.

A I'm left-handed so I lost a lot of my strength in my left hand. My left arm. Excuse me. My upper back and lower back. My hips. The pains are going down through my rear end to behind my up at my legs.

Q How bad are the pains?

A Very bad.

Q Describe them to the Judge.

A To the point I have to lay down. I can't sleep. My sleeping's so off and I have been in so much pain I have cried.

Q Once the pains start is there an average time they last or does it vary?

A Vary.

Q On a given week, what's the longest a specific pain will last?

A An hour or more.

Q Between 8:00 in the morning and 8:00 in the evening on an average day how much time do you spend either lying down or in a recliner?

A Five to six hours sometimes because I'm - - you know, I'm home all the time.

* * *

Q According to some reports you have arthritis in your knees. Do your knees hurt?

A Yes.

Q Tell the Judge about it.

A They feel like they're moving and especially in the left knee. And they get weak.

Q All right.

A And I limp. I have to drag my leg sometimes that I'm in that much pain.

Q Have you ever gotten shots anywhere for your pain?

A No, but the doctor and I have discussed it.

Q There's a mention in 2003 about you getting some injection in your left shoulder.

A Yes.

Q So, have you gotten shots?

A Yes.

Q You'd mentioned nightmares and there's some record - - some mention in the record of - - what are the nightmares about?

A There was a time when I was going through all of this I was getting threatening

and harassing phone calls.

Q And you still think about those?

A Yes, I do.

ATTY All right.

ALJ How do phone calls make you have nightmares?

CLMT Well, when you're living - -

ALJ [INAUDIBLE].

CLMT - - alone and when someone calls you talking about a situation and making comments yes, that's enough to scare. Is someone at your door?

* * *

ALJ Okay. Well, Counsel, one of the things I have to address and I don't mind you pushing the issue at all but I think on the psychological evaluation done in September of '05, a little over two years ago, it said that on a - - that's an IQ test. Full scale 71. This is a lady that took care of her mother. She operates a motor vehicle. She's been independent in her daily living. She was able to keyboard and do data entry for a financial firm. It sounds like she would have a higher IQ than 71. Do you want to help clarify that?

ATTY Well - -

BY ADMINISTRATIVE LAW JUDGE:

Q Ma'am, did you - - you got a high school diploma. Were you able to get good grades, poor grades? Did you take - -

A I was average.

Q Okay. You don't think of yourself as not smart? I mean, you were able to handle

your mom's money.

A Sir, you wouldn't even believe what I went through behind that all those years.

Q But you knew how to handle money?

A I know how to add and subtract, yes.

Q Okay. All right. Counsel, I just - -

A I don't understand.

ALJ I have to factor that in. I've got an IQ of 71. Are they right or am I hearing something different?

ATTY I agree that that's what the test says. I don't know whether the psychological factors that began more when she was taking care of her mother could have lowered it from what she had before.

ALJ Okay.

ATTY That - -

ALJ You were - -

ATTY - - could be - -

ALJ - - never held back in grade school?

CLMT No.

ALJ Okay. All right. All right. Counsel, just follow up with any other - - then they had diagnosed adjustment disorder with depressed mood but here she is on Cymbalta a couple years later so I don't know how reliable that test is.

ATTY Those are all the questions I had.

BY ADMINISTRATIVE LAW JUDGE:

Q It said Dr. Draper - - when did he come into the picture? Dr. Draper?

A I've been seeing Dr. Draper for years. Even when I was going to the free clinic.

Q It says variety of medical problems when I became disabled. Okay. Is he mentioned other places, Counsel? Dr. Draper. Here it is. Got him under six pages. Impingement of both shoulders, bilateral knee pain. Do you use a cane or orthopedic appliance? You told me you use a pillow?

A A posture pillow. Yes, sir.

Q But anything for your knees? Use a cane?

A No, sir.

Q And the - - and you need shoulder surgery because of torn ligaments on the left arm and you're right-handed?

A No, I'm left-handed.

E. Lifestyle Evidence

The following evidence concerning Claimant's lifestyle was obtained at the hearing and through medical records. The information is included in the report to demonstrate how Claimant's alleged impairments affect her daily life:

- Claimant drives to the laundromat and grocery store . (Tr. 51)
- Claimant took care of her "invalid mother". (Tr. 54-57)
- Claimant had power of attorney over her mother's financial assets. (Tr. 56)
- Claimant attends church monthly and can follow the sermon. (Tr. 59)
- Claimant is able to take care of herself. (Tr. 150)

- Claimant exercises every other day. (Tr. 150)
- Claimant attends to daily household chores and cleans once per month. (Tr. 150-152)
- Claimant prepares her own meals every two to three days. (Tr. 152)
- Claimant is able to take to handle her financials. (Tr. 153)

III. The Motions for Summary Judgment

A. Contentions of the Parties

Claimant contends that Claimant, Ms. Dozier, who was previously found disabled in 2002, is entitled to a presumption of continuing disability upon a subsequent SSI claim. Specifically, Claimant alleges that the Commissioner must rebut the presumption of continuing disability with evidence that Claimant's condition improved in the interim. Alternatively, Claimant alleges that even if she is not entitled to a presumption of continuing disability, the ALJ erred by failing to explicitly indicate the weight accorded to the 2002 award of SSI. Claimant also alleges that the jobs relied upon by the ALJ to conclude that there were jobs in significant numbers in the national economy Claimant could perform require more than simple instructions within the ability of Claimant, and therefore, these jobs are not responsive to her nonexertional limitations.

Commissioner maintains that Claimant was not entitled to a presumption of continuing disability, but bore the burden of establishing she was medically disabled and so functionally limited that she was unable to work. Commissioner further contends that the jobs identified by the vocational expert were within Claimant's ability level and range to complete sedentary work.

B. Discussion

1. Whether the ALJ Erred by Failing to Find Claimant is Entitled to a Presumption of Continuing Disability

Claimant asserts the ALJ's decision was not supported by substantial evidence because Claimant was entitled to a presumption of continuing disability following her prior award of SSI benefits. Alternatively, Claimant alleges even if she is not entitled to a presumption of continuing disability, the ALJ erred by failing to explicitly indicate the weight accorded to the prior award. The Commissioner counters Claimant was not entitled to a presumption of continuing disability, but bore the burden of establishing she was medically disabled and so functionally limited that she was unable to work.

"Initial determination of disability gives rise to a presumption that the disability continues. In order to rebut this presumption, the Secretary must come forward with evidence that the Claimant's condition has improved." *Crawford v. Sullivan*, 935 F.2d 655, 656 (4th Cir. 1991) (*citing Dotson v. Schweiker*, 719 F.2d 80 (4th Cir. 1983)). Claimant relies on *Crawford* and *Dotson* in arguing she is entitled to a presumption of continuing disability; however, both cases apply to termination of SSI benefits. Additionally, as explained in *Crawford*, subsequent to remand but prior to reconsideration, Congress enacted the Social Security Disability Benefits Reform Act of 1984. *Id*. (*see* 42 U.S.C. § 423). Section 423(f) provides that terminations must be based on substantial evidence of medical improvement; however, it does not establish a presumption of continuing disability. *Id*. Therefore, on remand, the Crawford case was considered under the new statutory language with no mention of a presumption of continuing disability. Claimant's reliance upon the case law is therefore misplaced because Claimant is not currently litigating termination of SSI.

Though the Fourth Circuit case law is silent as to presumption of continuing disability in

subsequent claims,[5] this issue need not be decided in this case because the ALJ erred in failing to indicate the weight given to the prior finding.

> When adjudicating a subsequent disability claim arising under the same or a different title of the Act as the prior claim, an adjudicator determining whether a claimant is disabled during a previously unadjudicated period must consider such a prior finding as evidence and give it appropriate weight in light of all relevant facts and circumstances. In determining the weight to be given such a prior finding, an adjudicator will consider such factors as: (1) whether the fact on which the prior finding was based is subject to change with the passage of time, such as a fact relating to the severity of a claimant's medical condition; (2) the likelihood of such a change, considering the length of time that has elapsed between the period previously adjudicated and the period being adjudicated in the subsequent claim; and (3) the extent that evidence not considered in the final decision on the prior claim provides a basis for making a different finding with respect to the period being adjudicated in the subsequent claim.

Acquiescence Ruling 00 - 1(4). Where the prior finding was one about a fact which is subject to change with the passage of time such as whether the claimant has an impairment that is severe, the likelihood that the fact has changed generally increases as the interval of time between the previously adjudicated period and the period being adjudicated increases. *Id.* As such, an

[5] Both Claimant and Commissioner argue non-binding authority. While decisions of other judicial jurisdictions have no bearing on this decision, the case law from other circuits indicates claimants are not entitled to a presumption of continuing disability. *See Stubbs-Danielson v. Astrue*, 539 F.3d 1169, 1172 (9th Cir. 2008) (holding that prior receipt of SSI benefits did not give rise to presumption of disability where reapplied for benefits six years after termination of benefits for nonmedical reasons); *Digiulio v. Astrue*, 2009 WL 800212, at 4 (D. Id.) (stating that recent Ninth Circuit case law indicates that a presumption of disability should not be applied where a Claimant reapplies for benefits more than one year after a nonmedical termination of benefits); *Nierzwick v. Com'r of Social Security*, 7 Fed. Appx. 358, 361 (6th Cir. 2001) (holding that even after a claimant has been found eligible for disability and SSI benefits, there is no presumption of continuing disability).

adjudicator should give greater weight to such a prior finding when the previously adjudicated period is close in time to the period being adjudicated in the subsequent claim, and adjudicators should give less weight to such a prior finding as the proximity of the period previously adjudicated to the period being adjudicated in the subsequent claim becomes more remote (e.g., where the relevant time period exceeds three years). *Id*.

Acquiescence Rulings explain how the SSA will apply decisions of the United States Courts of Appeals. AR 00-1(4) was issued to explain the effect of prior disability findings on adjudication of a subsequent disability claim. Specifically, AR 00-1(4) was meant to explain the Fourth Circuit decision in *Albright v. Com'r of Social Security Administration*, 174 F.3d 473 (4th Cir. 1999). Claimant correctly states that an ALJ, when adjudicating a subsequent disability claim arising under the same or a different Title of the Act as the prior claim, must consider a prior finding in a prior determination as evidence and give it appropriate weight in light of all the relevant facts and circumstances. (Cl. Br. P. 11).

The Court does not doubt that the ALJ could find Claimant not disabled in light of all the relevant facts and circumstances; however, the ALJ failed to consider the prior finding as evidence and give it appropriate weight in the analysis. The ALJ mentions the prior finding only once by merely stating that Claimant filed a prior application in 2000, and "in a decision issued on September 27, 2002, Administrate Law Judge Charles A. Stark found the claim 'disabled' as of her application date." (Tr. 32). The ALJ fails to consider any of the factors set forth in AR 00-1(4).

Additionally, the ALJ erred in his finding by failing to explicitly indicate the weight accorded to all medical evidence. "The role of the District Court is to address whether the ALJ

has analyzed all of the relevant evidence and sufficiently explained his rationale in crediting certain evidence in conducting the 'substantial evidence inquiry.'" *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 528 (4th Cir. 1998). However, the Court cannot determine if findings are supported by substantial evidence unless the weight given to all relevant evidence is "explicitly indicated." *Gordon v. Schweiker*, 725 F.2d 231, 235-36 (4th Cir. 1984). By failing to comply with *Albright* and AR 00-1(4), the ALJ also failed to comply with *Gordon* and its progeny in indicating the weight given to all relevant evidence.

Claimant is, therefore, correct in that the ALJ failed to consider the prior finding of disability. Though Claimant is not entitled to a presumption of continuing disability, the ALJ must follow AR 00-1(4) and give appropriate weight to the 2002 finding awarding SSI benefits.

2. Whether the ALJ Erred by Concluding there were Jobs in Significant Numbers in the National Economy Claimant could Perform.

Claimant asserts that the jobs relied upon by the ALJ to conclude that there were jobs in significant numbers in the national economy Claimant could perform require more than simple instructions within the ability of Claimant, and therefore, these jobs are not responsive to her nonexertional limitations. Commissioner counters that the jobs identified by the vocational expert were within Claimant's ability level and range to complete sedentary work.

Because the ALJ failed to properly address Claimant's prior disability finding, the ALJ's determination that Claimant could perform other work considering is improper. On remand, the ALJ, after affording appropriate weight to the prior disability finding, must reevaluate whether Claimant is able to do any other work considering her residual functional capacity, age, education, and work experience.

IV. Recommendation

For the foregoing reasons, I recommend that:

1. Claimant's Motion for Summary Judgment be **DENIED AND** this action be **REMANDED** because the ALJ failed to consider and give appropriate weight to the 2002 determination of ALJ Stark finding Claimant to be disabled. On remand, the ALJ must consider the prior finding and give it appropriate weight in light of all relevant evidence. Additionally, the ALJ must explicitly indicate the weight given to all relevant evidence in reaching his determination.

2. Commissioner's Motion for Summary Judgment be **DENIED** for the same reasons set forth above.

Any party who appears *pro se* and any counsel of record, as applicable, may, within ten (10) days of the date of this Report and Recommendation, file with the Clerk of the Court written objections identifying the portions of the Report and Recommendation to which objection is made, and the basis for such objection. A copy of such objections should be submitted to the District Court Judge of Record. Failure to timely file objections to the Report and Recommendation set forth above will result in waiver of the right to appeal from a judgment of this Court based upon such Report and Recommendation.

DATED: August 25, 2009

/s/ *James E. Seibert*
JAMES E. SEIBERT
UNITED STATES MAGISTRATE JUDGE